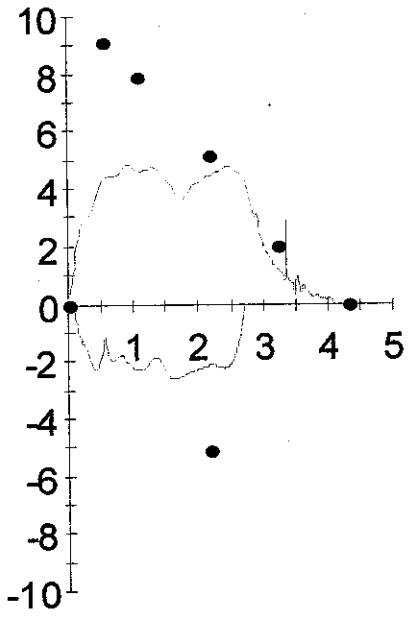
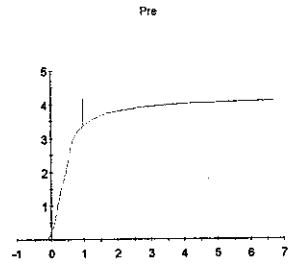
St. Clair Hospital

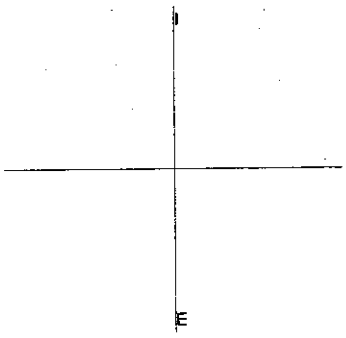
Pulmonary Function Report

1000 Bower Hill Rd.
Pittsburgh, PA, 15243
Phone: 412-942-2000 **Fax:** 412-942-2024

Name:	Kelly, Leslie	ID:	882590	D.O.B.:	12/17/1962	Date:	01/16/2007
Tech:	T. Zeman, CRT, RPsgT.	Height:	70.00	Age:	44	Room:	Outpatient
Doctor:	G. Fino, M.D.	Weight:	192.00	Sex:	Male	Race:	Black







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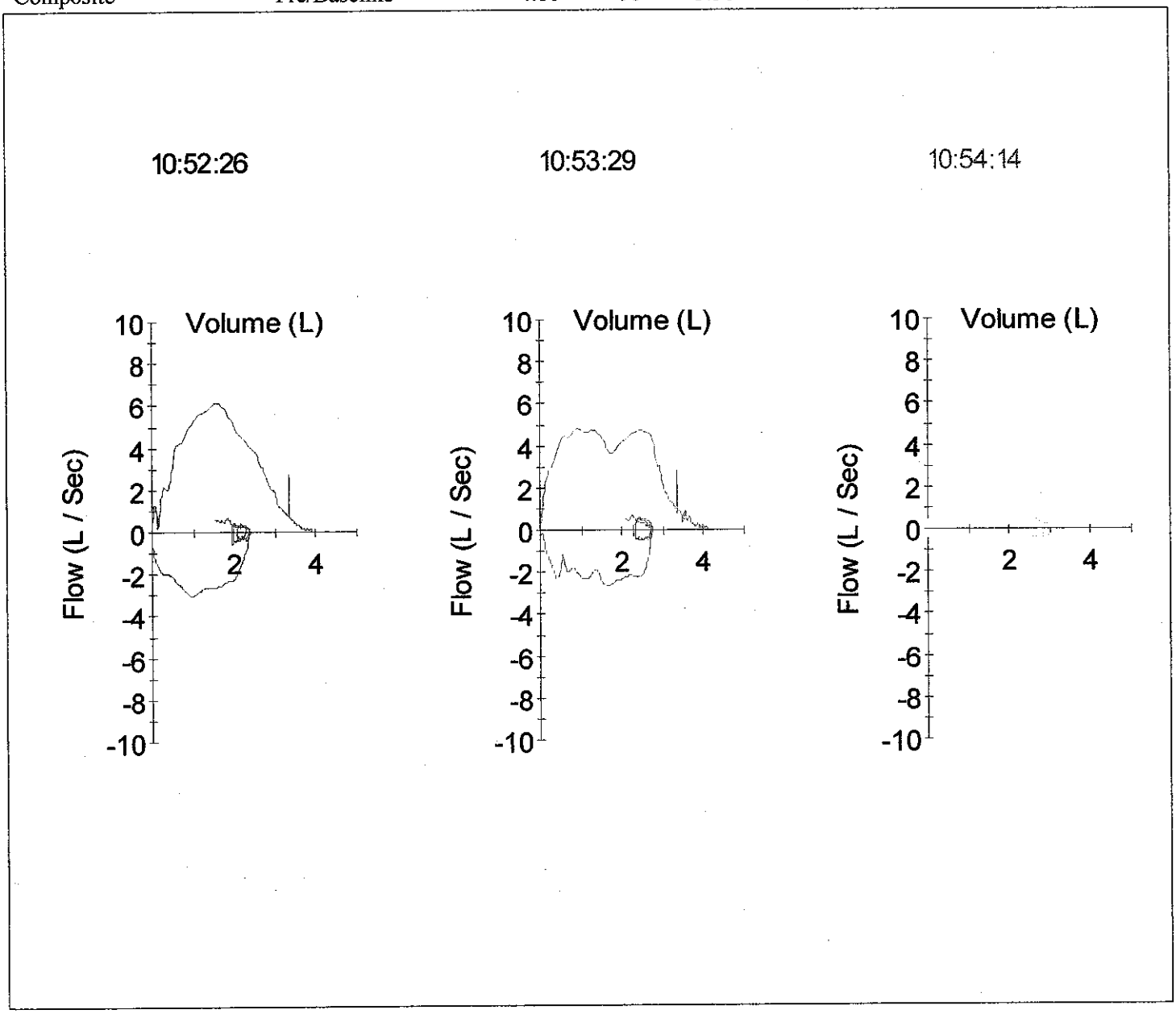
Time	Select	I-Lp	Test Mode	ATS	FVC absolute	FVC % p/c	FEV1 absolute	FEV1 % p/c	FEV1/FVC absolute	FEF 25-75% absolute
Pre										
10:53:29	*				4.10	95	3.38	97	82	3.91
10:52:26	*			back e	3.89	90	3.37	96	87	4.34
10:54:14	*			back e	3.93	91	3.28	94	84	3.60
Composite			Pre/Baseline		4.10	95	3.38	97	82	3.91



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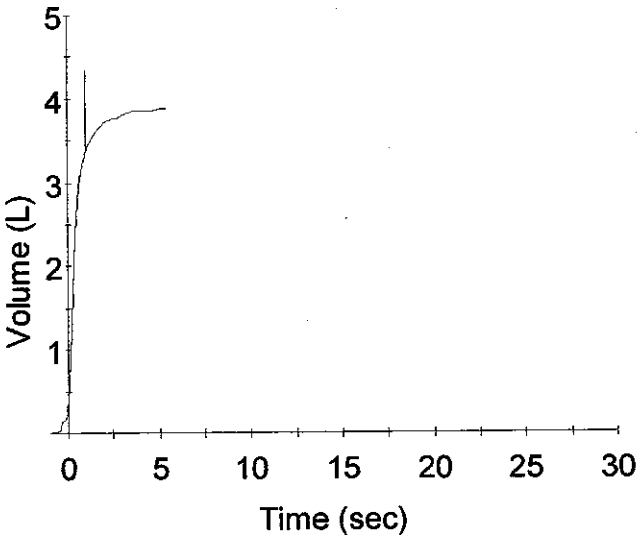

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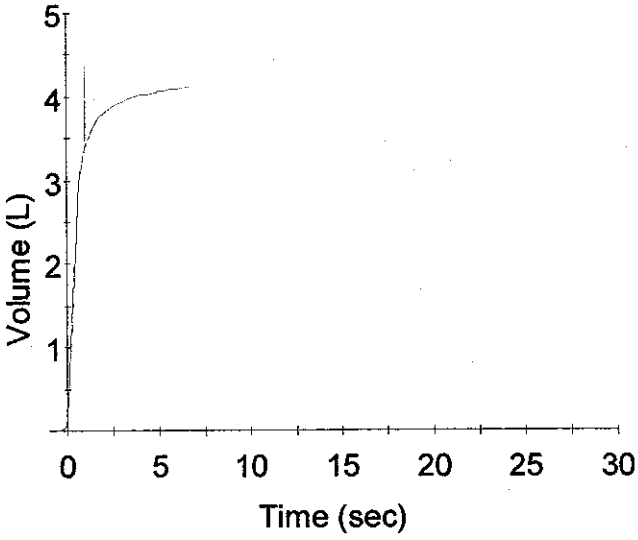

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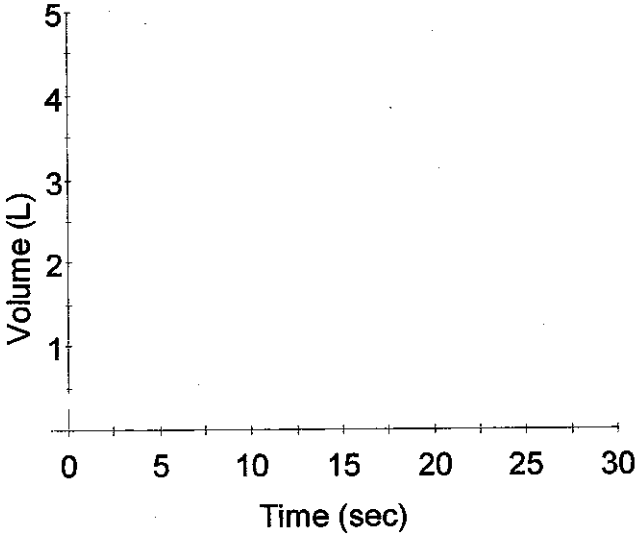

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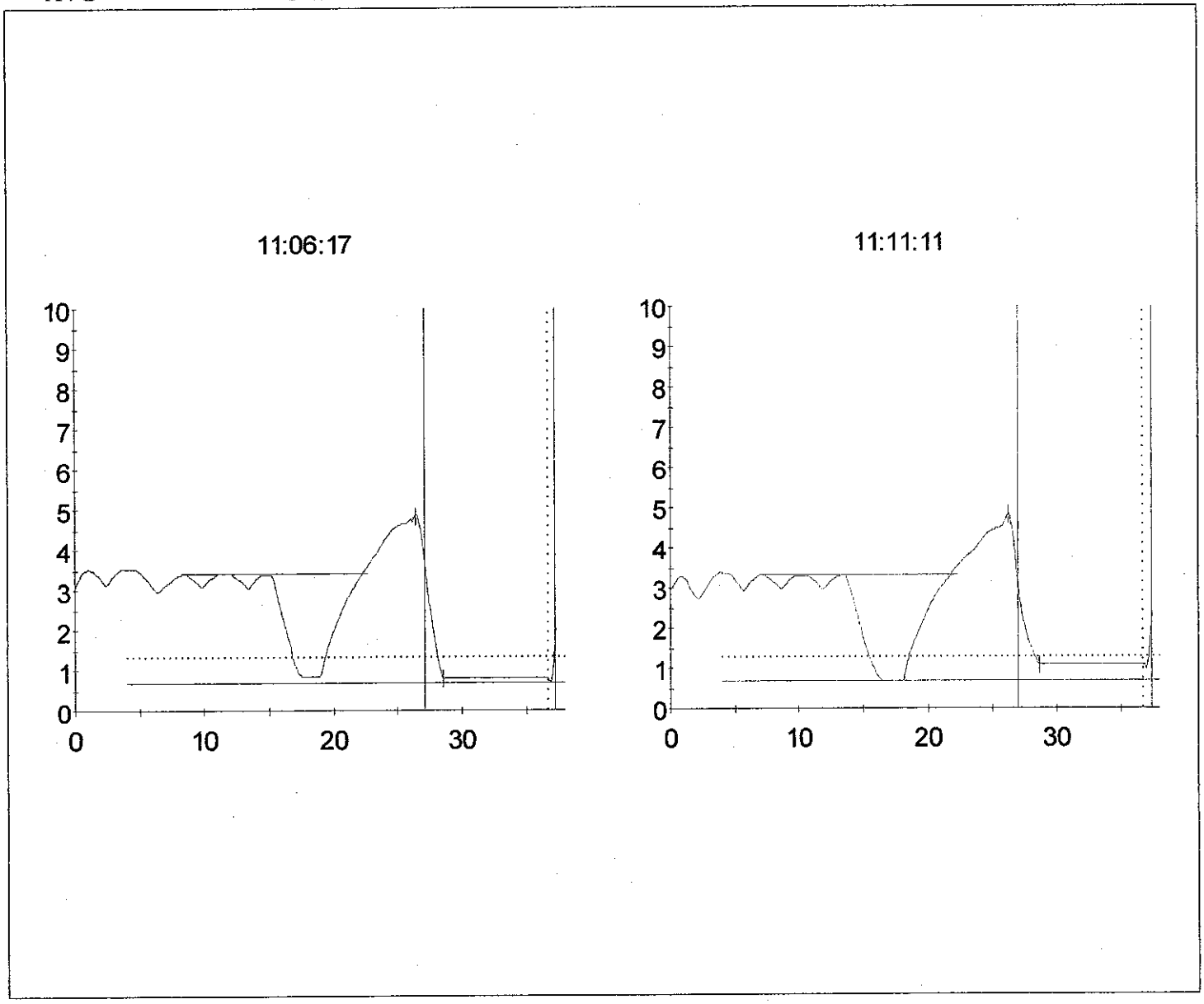
Doctor:	G. Fino, M.D.	Weight:	192.00	Sex:	Male	Race:	Black

Time	Select	RpLp	Test Mode	Codes	Protocol	DLCOunc absolute	DLCOunc % p/c	DLCOcor absolute	DLCOcor % p/c	DL/VA absolute
Predicted						37.99		37.35		5.58
Pre										
11:03:17				Inspirat	Jones-Mea	17.48	46			6.05
11:06:17	*				Jones-Mea	23.89	63			4.10
11:11:11	*				Jones-Mea	24.72	65			4.45
AVG			Pre/Baseline			24.31	64			4.27



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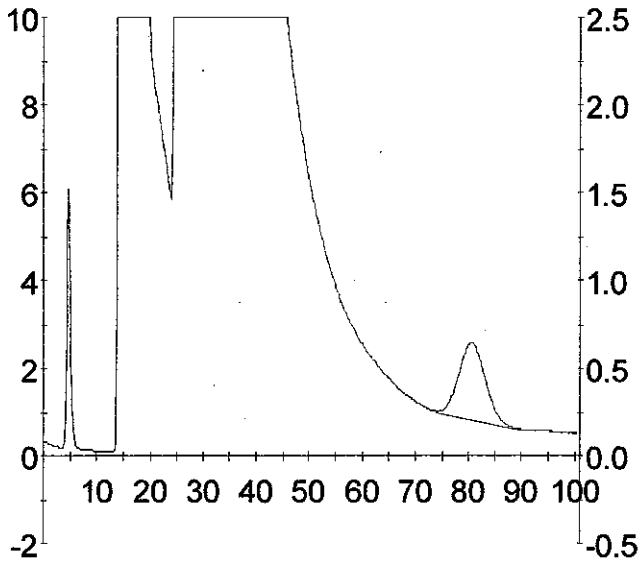
11:06:17



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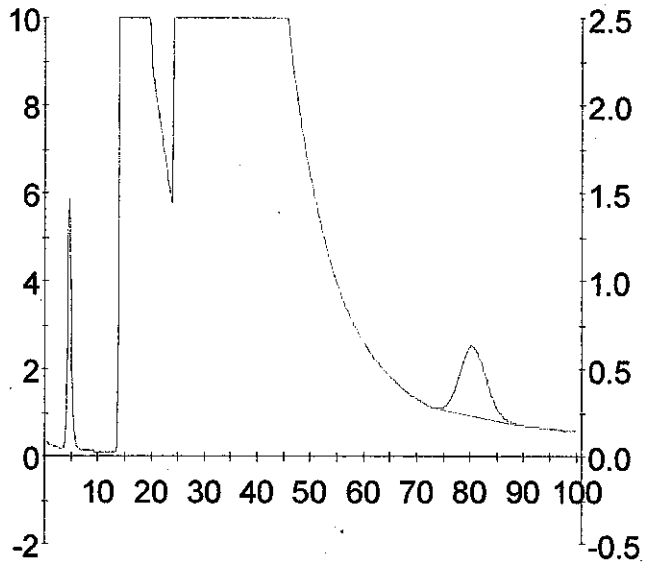

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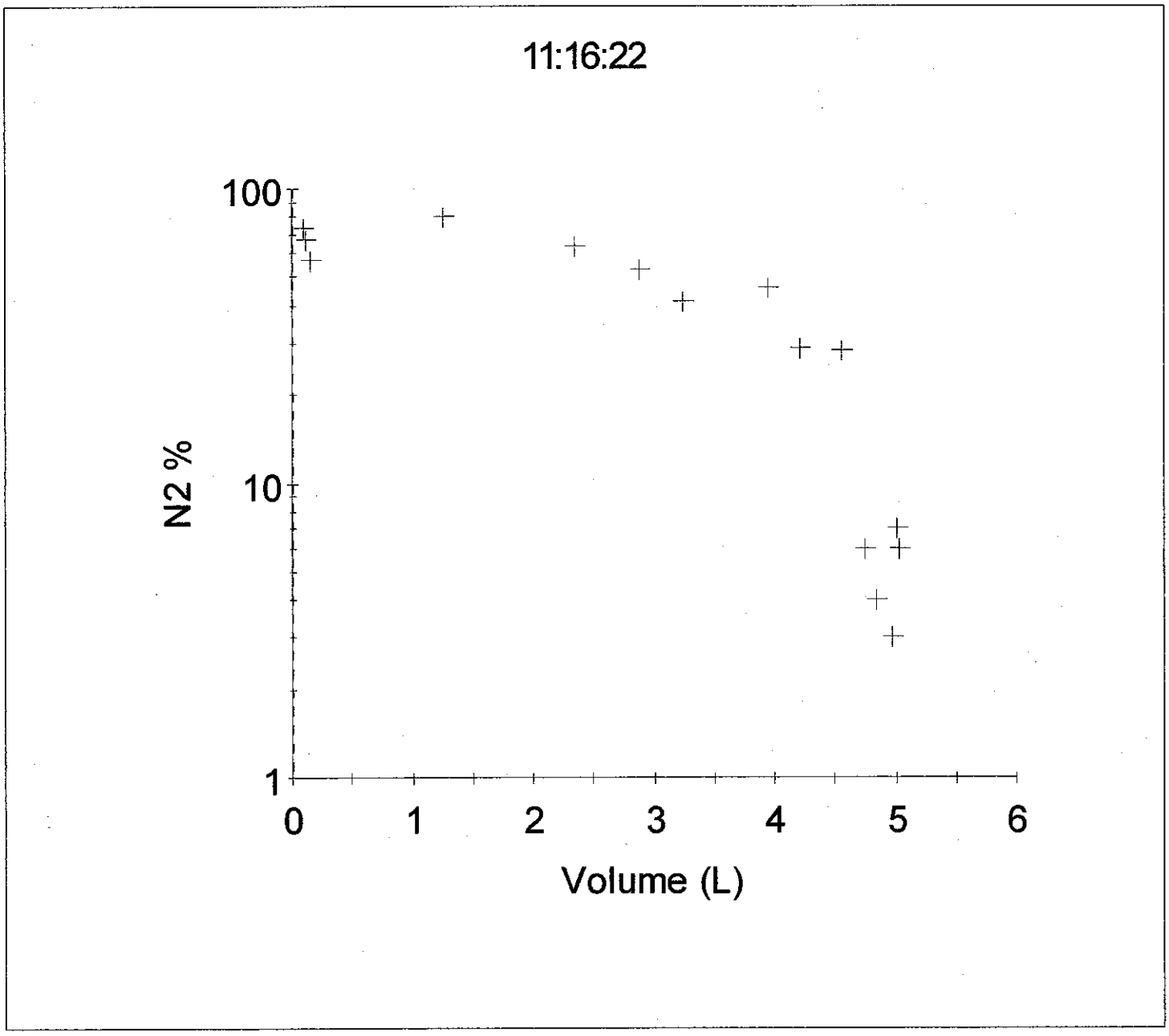
Doctor:	G. Fino, M.D.	Weight:	192.00	Sex:	Male	Race:	Black

Time	Select	RpLp	Test Mode	FRC (N2) absolute	FRC (N2) % p/c	RV (N2) absolute	RV (N2) % p/c	TLC (N2) absolute
Predicted				3.47		2.07		7.13
Pre								
11:16:22	*			4.95	143	3.47	168	7.65
AVG			Pre/Baseline	4.95	143	3.47	168	7.65



KELLY,LESLIE
MR#:882590 SEX:M AGE:44Y BIRTH:12/17/1962
DOCTOR:FINO, GREGORY J., M.D.
1000 BOWER HILL RD. SUITE 211
PITTSBURGH PA 15243

ST CLAIR HOSPITAL LABORATORY
1000 BOWER HILL ROAD
PITTSBURGH, PA 15243
MARTHA R. CLARKE,MD, MEDICAL DIRECTOR

========== PHYSICIAN COPY FOR DR: FINO, GREGORY J., M.D. ==========

T5683 COLL: 01/16/2007 11:48 REC: 01/16/2007 11:51

COMP METABOLIC			
SGOT/AST	23	[0-50]	U/L
SGPT/ALT	46	[0-50]	U/L
ALKALINE PHOSPHAT	72	[43-122]	U/L
BILIRUBIN TOTAL	0.5	[0.2-1.3]	MG/DL
PROTEIN	7.5	[6.0-8.4]	G/DL
ALBUMIN	4.4	[3.5-5.0]	G/DL
CALCIUM	9.8	[8.0-10.2]	MG/DL
GLUCOSE	77	[70-110]	MG/DL
BUN	9	[8-25]	MG/DL
CREATININE	1.1	[0.6-1.5]	MG/DL
GFR(CAUCAS/OTHER)	>59	[>59]	ML/MIN
GFR(AFRICAN AMER)	>59	[>59]	ML/MIN
SODIUM	139	[133-145]	MMOL/L
POTASSIUM	4.5	[3.5-5.0]	MMOL/L
CHLORIDE	104	[96-108]	MMOL/L
CO2	28	[22-30]	MMOL/L
ANION GAP	@7	[8-16]	MMOL/L
CBC HEMOGRAM			
WBC	5.9	[4.8-10.8]	K/UL
RBC	5.71	[4.7-6.2]	M/UL
HEMOGLOBIN	15.9	[14.0-17.0]	GM/DL
HEMATOCRIT	46.4	[42.0-52.0]	%
MCV	81.3	[78.0-94.0]	FL
MCH	27.8	[25.0-35.0]	PG
MCHC	34.3	[31.0-36.5]	G/DL
RDW	14.4	[12.9-14.9]	%
PLATELET	173	[130-460]	K/UL
MPV	9.6	[7.4-10.4]	FL
DIFF,ELECTRONIC			
ABSOLUTE NEUTROPH	3.1	[1.5-6.6]	K/UL
ABSOLUTE LYMPHOCY	2.5	[1.5-3.5]	K/UL
ABSOLUTE MONOCYTE	0.2	[0-0.9]	K/UL
ABSOLUTE EOSINOPH	0.2	[0-0.6]	K/UL
ABSOLUTE BASOPHIL	0.0	[0-0.1]	K/UL
NEUTROPHIL	52.9	[40-75]	%
LYMPHOCYTE	39.4	[20-40]	%
MONOCYTE	4.1	[1-8]	%
EOSINOPHIL	2.8	[0-5]	%
BASOPHIL	0.8	[0-1]	%

PAGE:1
1TIME
* = CRITICAL VALUE
@ = OUTSIDE NORMAL RANGE
END OF REPORT

FINO, GREGORY J., M.D.
1000 BOWER HILL RD. SUITE 211
PITTSBURGH PA 15243

[redacted]

LAB-208(7/98)

CLINICAL & OCCUPATIONAL PULMONARY ASSOCIATES, LLC

Gregory J. Fino, MD, FCCP

St. Clair Hospital
1000 Bower Hill Road, Suite 211
Pittsburgh, Pennsylvania 15243-1899

Telephone (412) 942-2025
Fax (412) 942-2032
Email gregory.fino@stclair.org

PATIENT Kelly, Leslie

DATE 1/16/07

PULSE OXIMETRY

99% RA

CC = 3 ppm

0.6 COHb

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Gregory J. Fino, MD, FCCP

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January 22, 2007

Michael C. Colville
Assistant U.S. Attorney
U.S. Department of Justice
U.S. Post Office & Courthouse
700 Grant Street
Suite 4000
Pittsburgh, PA 15219

RE: Kevin Siggers v. United States
C.A. No. 03-335E
SSN: 294-80-1228
DOB: 8/22/70
OIME: 1/2/07

Dear Attorney Colville:

I examined Mr. Siggers on January 2, 2007.

Patient Profile

Mr. Siggers was born in 1970 and is 36 years old.

His medications included:

1. Albuterol inhaler - used as needed; not used on the day of this evaluation; estimates that he has been on an inhaler for 2 years or so; he believes it helps "a little bit." He uses the inhaler for chest pain and shortness of breath.
2. Finishing up a course of antibiotics today (prescribed for a "head cold").

He smoked off and on between the mid 1980s and 2004. He estimates that he smoked for about 7 of those years. He sometimes smoked cigars and at other times he smoked cigarettes. He only smoked 3-4 cigarettes or cigars per day - sometimes less than that. He also used cannabis off and on until about 1990.

Occupational History

Mr. Siggers worked for Unicor from 1999 until December 20, 2006. He cut the Micore Board until he switched to another job in October of 2003. He said that the ventilation was not good and that he was offered a garden mask (paper) but not a respirator. When he moved to his new position, he was not exposed as much to the particle board; however, he still had daily exposure to it. The Micore board was removed from the facility at the end of 2004. Mr. Siggers stated that although he was also exposed to the Lokweld adhesive, he believes that the Micore board was the problem.

He was also exposed to wood dust.

Early on in his work, he complained of shortness of breath and episodes of a bloody nose. He had to walk up an incline to get to his living quarters, and he noted shortness of breath when doing so. He has been short of breath since 1999. He also complains of tightness in his chest which he describes as a fist in the center of his chest.

Since the Micore board was removed from Unicor (in 2004), he continues to have shortness of breath and a tightness in his chest. The tightness in the chest can occur at rest and with exertion.

He has a dry cough with little mucous production. He does wheeze.

He also complains of a rash. He had to have a skin abscess drained from the back of his neck and his forearm. He also complained of dry skin. He noted that when he was not around the Micore, he would not have much itching. However, he still complains of itching over his elbows. He has been treated with Benadryl for the itching.

He is also worried about developing silicosis down the road.

He has never been worked up for heart disease.

Past Medical History

1. Right hip replacement in 1984 - due to football injury; he had broken his pelvic socket bone
2. Hospitalized for pneumonia in the mid 1970s

3. Nurse's assistant at the prison diagnosed asthma in 2003 or 2004
4. He estimates 2 to 3 head colds per year
5. See above notes re: skin abscess

He has no history of tuberculosis, emphysema, bronchitis or bronchiectasis. There is no history of fractured ribs.

Family History

There is no family history of lung disease or malignancy. There is a family history of diabetes (paternal grandfather, father and brother). There is also a family history of high blood pressure (paternal grandfather, father and brother).

Review of Systems

Neurologic:	No headaches or seizures
HEENT:	No chronic sinus problems
GI:	No history of chronic gastrointestinal disease
GU:	No chronic genitourinary problems
Endocrine:	No diabetes or thyroid disease

Physical Examination

General:	Well-developed, well-nourished African American man in no acute distress, oriented X 3
Heart Rate:	70
Blood Pressure:	145/82
Respiratory Rate:	16
Height:	71" without shoes

Weight:	264 lbs without shoes
Skin/Nails:	No cyanosis, clubbing, or edema
Neck:	Supple with a midline trachea; no thyromegaly
HEENT:	Unremarkable
Lungs:	Clear to auscultation and percussion on a tidal volume breath and a forced expiratory maneuver without wheezes, rales, rhonchi, or rubs
Heart:	Normal S1 and S2 without murmurs, gallops, or rubs
Abdomen:	No organomegaly
Peripheral Pulses:	2+ and equal
Extremities:	Negative
Edema:	Negative
Neurological Exam:	Intact

Chest X-Ray

A two-view chest x-ray was performed in conjunction with this examination. The chest x-rays were compared to the revised 2000 ILO classification films.

I have also received for review the following radiographic studies, and I have compared all of the chest x-rays to the revised 2000 ILO classification films:

1. A Quality 1 PA film dated 7/23/03 performed at an unspecified facility.

2. A Quality 1 PA film dated 12/30/03 also performed at an unspecified facility.

There were no pleural and no parenchymal abnormalities consistent with an occupationally acquired pneumoconiosis, and I classified all of the above-referenced chest x-rays as 0/0.

Pulmonary Function Testing

The American Thoracic Society, in conjunction with the European Respiratory Society, has published a follow-up article to their 1991 article on selection of reference values and interpretative strategies in pulmonary function testing.

The original 1991 article is entitled Lung Function Testing: Selection of Reference Values And Interpretative Strategies **(AM REV RESPIR DIS 1991; 144:1202-1218).** The more recent article is entitled Interpretative Strategies for Lung Function Tests **(EUR RESPIR J 2005; 26:948-968).**

The following consensus recommendations have been issued in the 2005 consensus statement:

- ✓ If the patient's age or height is outside the limits of the reference population, a statement in the interpretation should indicate that an extrapolation has been made.
- ✓ The practice of using 80% as a fixed value for the lower limit of normal can lead to important errors when interpreting lung function in adults. The practice of using 0.70 as a lower limit of the FEV1/FVC ratio results in a significant number of false positive results in males aged greater than 40 years and females greater than 50 years, as well as in a risk of over diagnosis of chronic obstructive pulmonary disease in asymptomatic elderly never smokers.
- ✓ Volume corrections should be made for African-Americans and Hispanics when measuring spirometry. Values for lung volumes are, on average, 12% lower in African-Americans than in Caucasians.
- ✓ Recommended spirometric reference equations come from the National Health and Nutrition Examination Survey (NHANES III) published in 1999 **(AM J RESPIR CRIT CARE MED 1999; 159:179-187).**
- ✓ Recommended lung volume reference equations were published in 1995 **(EUR RESPIR J 1995; 8:492-506).**

✓ A single set of diffusing capacity reference values could not be recommended. There were two commonly used equations referenced, one of which has been utilized since its publication in 1981 **(AM REV RESPIR DIS; 123:185-189).**

The earlier consensus statement also recommended abandoning the 80% cut off as normal and the 70% cut off for the FEV1/FVC. The new 2005 statement paper goes one step further and has recommended utilization of one set of reference equations for spirometry, one for lung volumes and then one of two for the diffusing capacity. Having reviewed these new recommendations and having reviewed the source material, I believe that it is medically reasonable to follow the recommendations in the statement papers.

I have included with the pulmonary function studies that are performed in conjunction with my examinations a new summary for the spirometry, lung volumes and diffusing capacity. This summary utilizes the above noted recommendations for the spirometry, lung volume and diffusing capacity reference equations.

Spirometry

The spirometry was invalid because of a premature termination to exhalation and a lack of reproducibility in the expiratory tracings. There was also a lack of an abrupt onset to exhalation. The values recorded for this spirometry represent at least the minimal lung function that this man could perform and certainly not this man's maximum lung function. (References: (1) Standardization of Spirometry. *A.R.R.D.* 1987; 136:1285-1298. (2) ATS Statement-Snowbird Workshop on Standardization of Spirometry. *A.R.R.D.* 1979; 119:831-838. (3) Statement on Spirometry. *Chest* 1983; 83:547-550. (4) ATS/ERS Task Force:Standardization of Lung Function Testing - Standardization of Spirometry. Eur Respir J 2005; 26: 319-338.)

Lung Volumes

The residual volume was increased. Other than that, this study was normal.

Diffusing Capacity

The diffusing capacity was invalid because the inspiratory vital capacity was less than 90% of the forced vital capacity. However, when taking into consideration alveolar volume, the diffusing capacity was normal.

Oxygen Saturation

Normal

Carboxyhemoglobin Level

Normal

Laboratory Results

Complete blood count, liver panel and renal function were all normal.

Medical Record Review

In conjunction with this evaluation, I also reviewed the following information:

1. Background information which included:

   - The Microbac Indoor Airy Quality Survey dated 7/31/01.
   - The Declaration of Michael Salerno, dated 1/19/05, with detailed information regarding the ventilation system.
   - The McKean time line, which identified when and where the Plaintiff worked within the UNICOR Factory.
   - Material Safety Data Sheets for Micore Board
   - The OSHA Inspection Report and supporting documentation.

   Micore Board is a man-made product which contains man-made vitreous fiber, expanded perlite, starch, recycled paper, kaolin and crystalline silica.

   Lokweld is a sprayed grade adhesive used for laminate. It contains acetone, toluene, hexane isomers, and N-hexane.

In a letter dated August 20, 2003, Mr. Stranahan (from OSHA) discussed the air monitoring results that had been taken to evaluate the workers' exposure to concentrations of airborne dust. In this letter he stated that the "results showed no worker's exposure exceeded 10% of the relevant exposure limit." He also recommended a number of steps that could be voluntarily taken to eliminate and/or further reduce the workers' exposure to dust. OSHA found no evidence of first marble silica.

2. A copy of the Amended Complaint.

3. The Declarations of Debora Forsyth, Assistant Warden, dated 7/27/04 and 1/30/06.

4. The Declaration of Joyce Horikawa, Senior Attorney Advisor, dated 7/30/04.

5. The Declarations of Martin Sapko, Factory Manager, dated 7/30/04 and 1/25/06.

6. The Declaration of Dennis Olson, M.D., dated 7/30/04, including his summary of the Plaintiff's medical attention at FCI McKean.

7. A true and correct copy of the Plaintiff's medical records attached to Dr. Olson's Declaration of 7/30/04.

8. The Declaration of Stephen Housler, Safety Manager, dated 1/25/06.

9. A transcript of the video conference deposition of Mr. Siggers dated 10/31/06.

10. In addition to the information noted above, I also had an opportunity to review miscellaneous records on CD ROMS that accompanied the files forwarded to my office.

Diagnosis

Normal Pulmonary Examination

Discussion

I find no evidence of a respiratory impairment or disability. This man's spirometry was invalid; his diffusing capacity was also invalid, but it was normal when taking into consideration alveolar volume.

The determination of pulmonary impairment and subsequent disability has been extensively researched in the American medical literature. In the late 1980s, there was a worldwide conference on the assessment of respiratory impairment sponsored by the National Institutes of Health. This was published in the American Review of Respiratory Disease in 1988 (ARRD 1988; 137:1505-1510). All of the participants agreed that symptoms of shortness of breath on effort and exercise intolerance were not reliable predictors of impairment. There was also agreement that a physical examination was not helpful in measuring pulmonary impairment. Lung function tests, however, were essential in assessing whether or not impairment was present and essential in rating its severity. Dr. Hans Weill commented that "resting lung function tests, usually spirometry, all are the cornerstone in the clinician's assessment of respiratory impairment, and provided they are technically sound, are generally believed to be adequate for ascertaining the presence of respiratory limitation. Likewise, it is generally believed that exercise limitation is not likely to be present in the face of normal or marginal resting lung function."

Similar statements have been issued by the American Thoracic Society and the American Medical Association with respect to guidelines for the evaluation of respiratory impairment. It is of utmost importance that valid lung function studies be performed. An invalid study does not represent the patient's maximum pulmonary capacity and cannot be used to assess impairment or disability. An invalid pulmonary function study indicates poor patient effort. The values recorded can only represent the minimum lung function of the patient.

According to his history, Mr. Siggers is still quite active. If indeed this man really had the lung function that was depicted in the invalid spirometry, he would not be able to be that active.

There is no evidence of either chronic or accelerated silicosis based on the normal chest films.

This patient should have no fear of contracting silicosis in the future. First of all, there were no measurable levels of respirable silica noted by OSHA. Furthermore, it is well documented in the medical literature that at least 20 years of exposure to dust that is measurable and above the PEL is required before chronic silicosis occurs.

If Mr. Siggers were my patient, I would not follow him for the subsequent development of silicosis, and I would assure him that he has no reason to worry about developing silicosis in the future.

I find no evidence of any chronic condition with reference to his eyes or throat or skin.

This patient has been diagnosed with asthma. As I reviewed the medical records, I found no evidence to support that diagnosis. That is based on the lack of findings of wheezing as well as a lack of any lung function studies that showed changes consistent with asthma. I would note that, at times, there were measurements of peak flow. However, those are unacceptable in this case because I have no idea whether this man gave a good effort. Suffice it to state that there is no objective evidence of an asthmatic condition.

Conclusions

My conclusions have been reached with a reasonable degree of medical certainly. I find no evidence of any chronic condition of the lungs or pulmonary system related to his alleged exposures. I find no evidence of a chronic condition with reference to the skin, eyes or nose.

Sincerely,

Gregory J. Fino, M.D., F.C.C.P.

GJF/kms

CLINICAL AND OCCUPATIONAL PULMONARY ASSOCIATES

GREGORY J. FINO, M.D., F.C.C.P.

PREDICTED VALUES BASED ON THE 2005 SPIROMETRY RECOMMENDATIONS

Recommendations from the ATS/ERS : INTERPRETATIVE STRATEGIES FOR LUNG FUNCTION TESTS EUR RESPIR J 2005; 26:948-968.

Name	Siggers, Kevin		MD	Fino
Ht	180.3	cm	Date	1/2/2007
Age	36	years	Race	African American

SPIROMETRY PREDICTED VALUES USING THE NHANES III STUDY

Spirometric Reference Values from a Sample of the General U.S. Population

AM J RESPIR CRIT CARE MED 1999; 159:179-187

TEST	PATIENT	PRED	%PRED	LLN	LLN%
FVC	3.12	4.60	68	3.64	79
FEV1	2.15	3.80	57	2.94	77
FEV1/FVC	69	83		72	
FEF25-75	1.88	4.02	47	2.19	54

REFERENCE VALUES FOR RV,FRC AND TLC - ATS WORKSHOP ON LUNG VOLUME MEASUREMENTS OFFICIAL STATEMENT OF THE EUROPEAN RESPIRATORY SOCIETY

EUR RESPIR J 1995; 8:492-506

L.V.	PATIENT	PRED	%PRED	LLN	LLN%	ULN	ULN%
TLC	5.32	6.45	83	5.24	81	8.70	135
RV	2.38	1.69	141	1.10	65	2.59	153
FRC	2.94	3.07	96	2.20	72	4.48	146
RV/TLC%	45	28	160	17	62	39	138

STANDARDIZED SINGLE BREATH NORMAL VALUES FOR THE DLCO

AM REV RESPIR DIS 1981;123:185-189

DLCO	PATIENT	PRED	%PRED	LLN	LLN%
DLCO	26.12	35.89	73	28.67	80
DL/VA	6.00	5.15	116	3.92	76

Prebronchodilator

FVC
FEV1
FEV1/FVC
FEF25-75

Post Bronchodilator

FVC
FEV1

Lung Volumes

FRC
TLC
RV
RV/TLC

Diffusing Capacity

DLCO
DL/VA

IMPRESSION

PRE	
FVC	3.12
FEV1	2.15
FEV1/FVC	69
FEF25-75	1.88
TLC	5.32
RV	2.38
FRC	2.94

PRE	
RV/TLC%	45
DLCO	26.12
DL/VA	6

Gregory J. Fino, M.D.

St. Clair Hospital

Pulmonary Function Report

1000 Bower Hill Rd.
Pittsburgh, PA, 15243
Phone: 412-942-2000 **Fax:** 412-942-2024

Name:	Siggers, Kevin	ID:	88-19-57	D.O.B.:	08/22/1970	Date:	01/02/2007
Tech:	Bozic, J. RRT	Height:	71.00	Age:	36	Room:	Outpatient
Doctor:	G. Fino, M.D.	Weight:	264.00	Sex:	Male	Race:	Black

Diagnosis: SOB
Dyspnea: After any exertion Cough: Non-Productive Wheeze: No Wheeze
Tbco Prod: Cigarette Yrs Smk: 7.0 Pks/Day: 3.0 Yrs Quit: 2.0
Medications:
Pre Test Comments:
Post Test Comments: Patient met ATS standards. PFT Authors DLCO (Crapo), FVC (Nhanes III), FRC (ECCS)

	Pre-Bronch			Post-Bronch		
	Actual	Pred	%Pred	Actual	%Pred	%Chng
---- SPIROMETRY ----						
FVC (L)	3.12	4.61	68			
FEV1 (L)	2.15	3.80	57			
FEV1/FVC (%)	69	83	83			
FEF 25% (L/sec)	2.27	9.09	25			
FEF 75% (L/sec)	1.06	2.20	48			
FEF 25-75% (L/sec)	1.88	4.02	47			
FEF Max (L/sec)	2.56	9.65	27			
FIVC (L)	2.47					
FIF Max (L/sec)	1.80					
---- LUNG VOLUMES ----						
SVC (L)	2.94	5.32	55			
IC (L)	2.38	3.57	67			
ERV (L)	0.56	1.75	32			
FRC (N2) (L)	2.94	3.45	85			
RV (N2) (L)	2.38	1.92	124			
TLC (N2) (L)	5.32	7.33	73			
RV/TLC (N2) (%)	45	28	160			
Washout Time (min)	2.12					
---- DIFFUSION ----						
DLCOunc (ml/min/mmHg)	26.12	40.80	64			
DLCOcor (ml/min/mmHg)		40.80				
DL/VA (ml/min/mmHg/L)	6.00	5.86	102			
VA (L)	4.36	7.12	61			
IVC (L)	2.48					
BHT (sec)						

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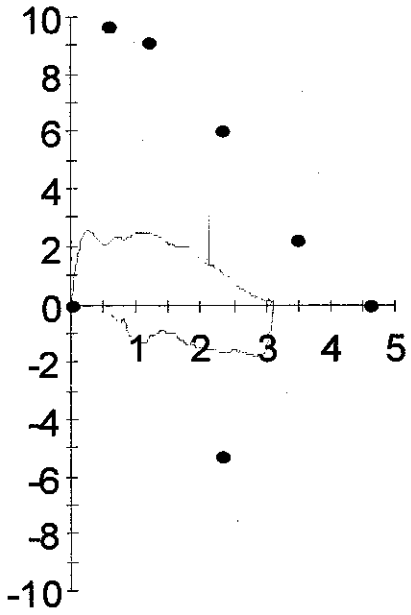

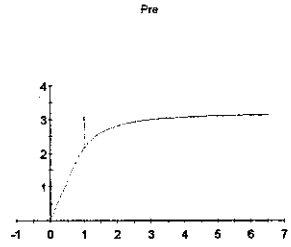

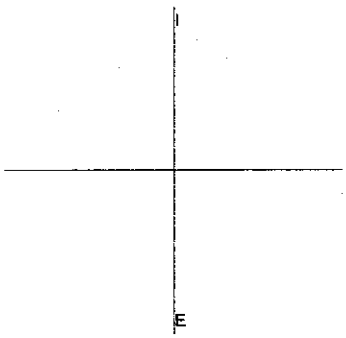

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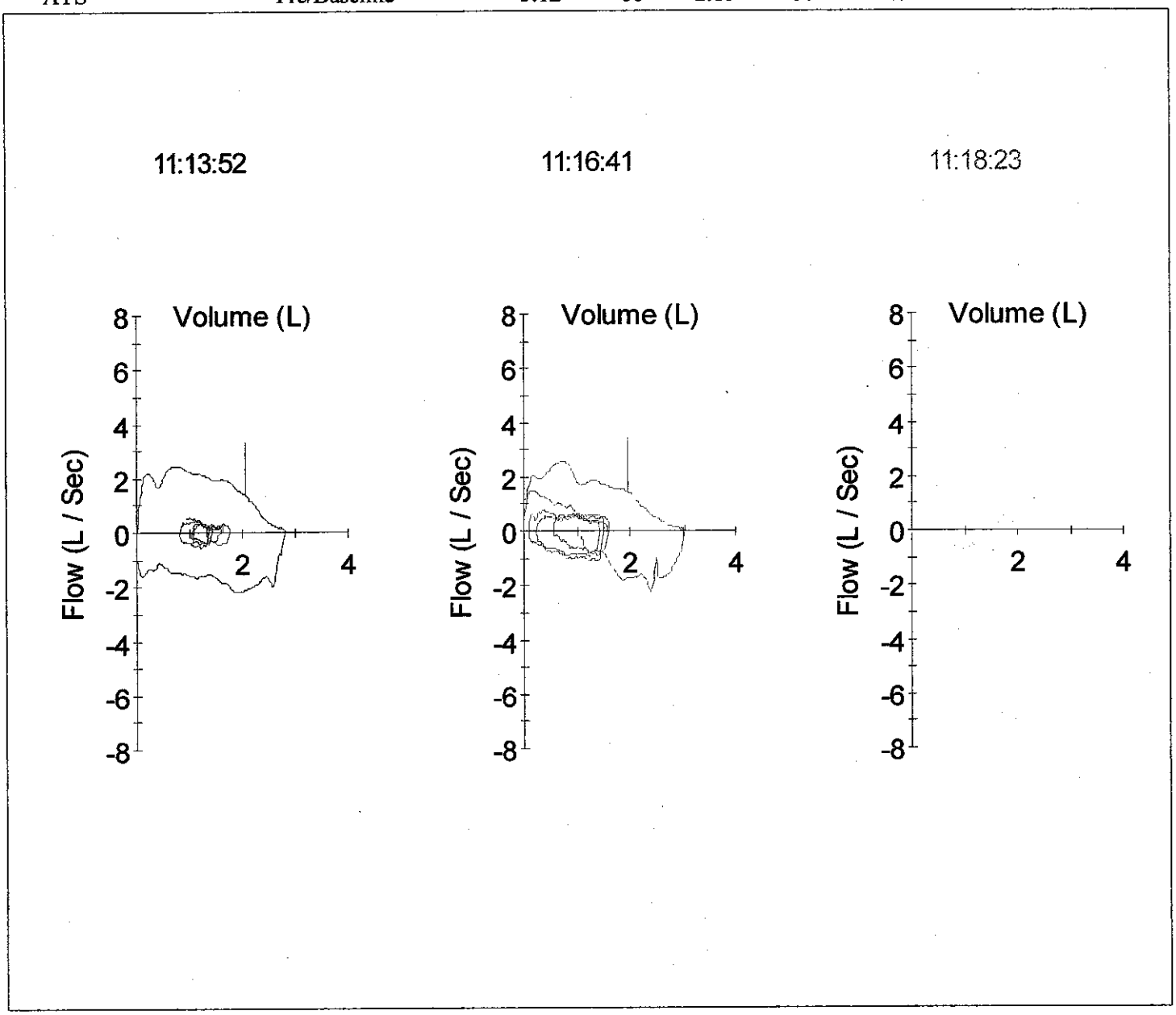
Doctor:	G. Fino, M.D.	Weight:	264.00	Sex:	Male	Race:	Black

Time	Select	I-Lp	Test Mode	ATS	FVC absolute	FVC % p/c	FEV1 absolute	FEV1 % p/c	FEV1/FVC absolute	FEF 25-75% absolute
Pre										
11:18:23	*				3.12	68	2.15	57	69	1.88
11:16:41	*				3.06	66	1.99	52	65	1.54
11:13:52	*				2.82	61	2.09	55	74	1.93
ATS			Pre/Baseline		3.12	68	2.15	57	69	1.88



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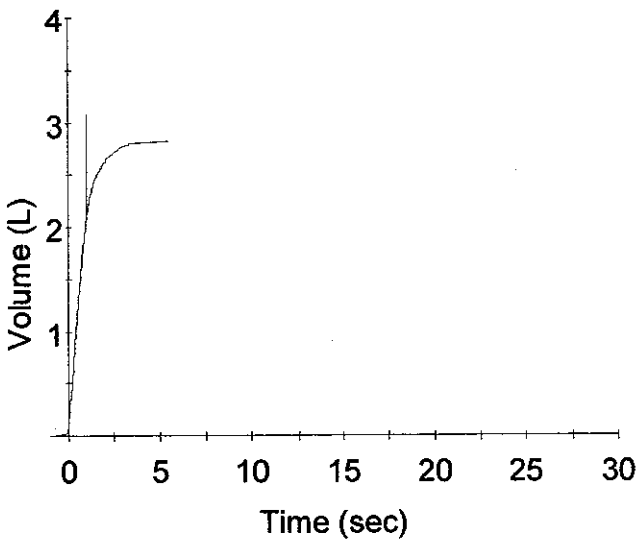

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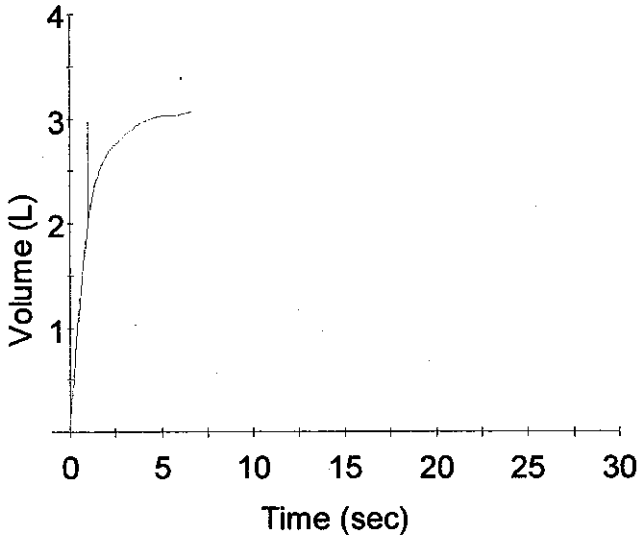

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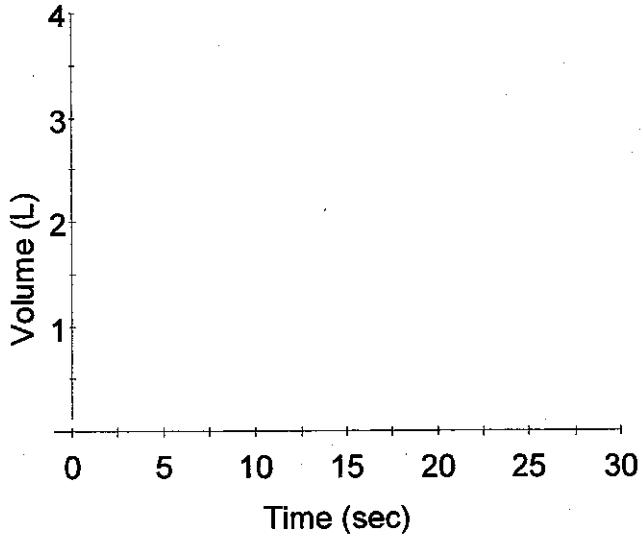

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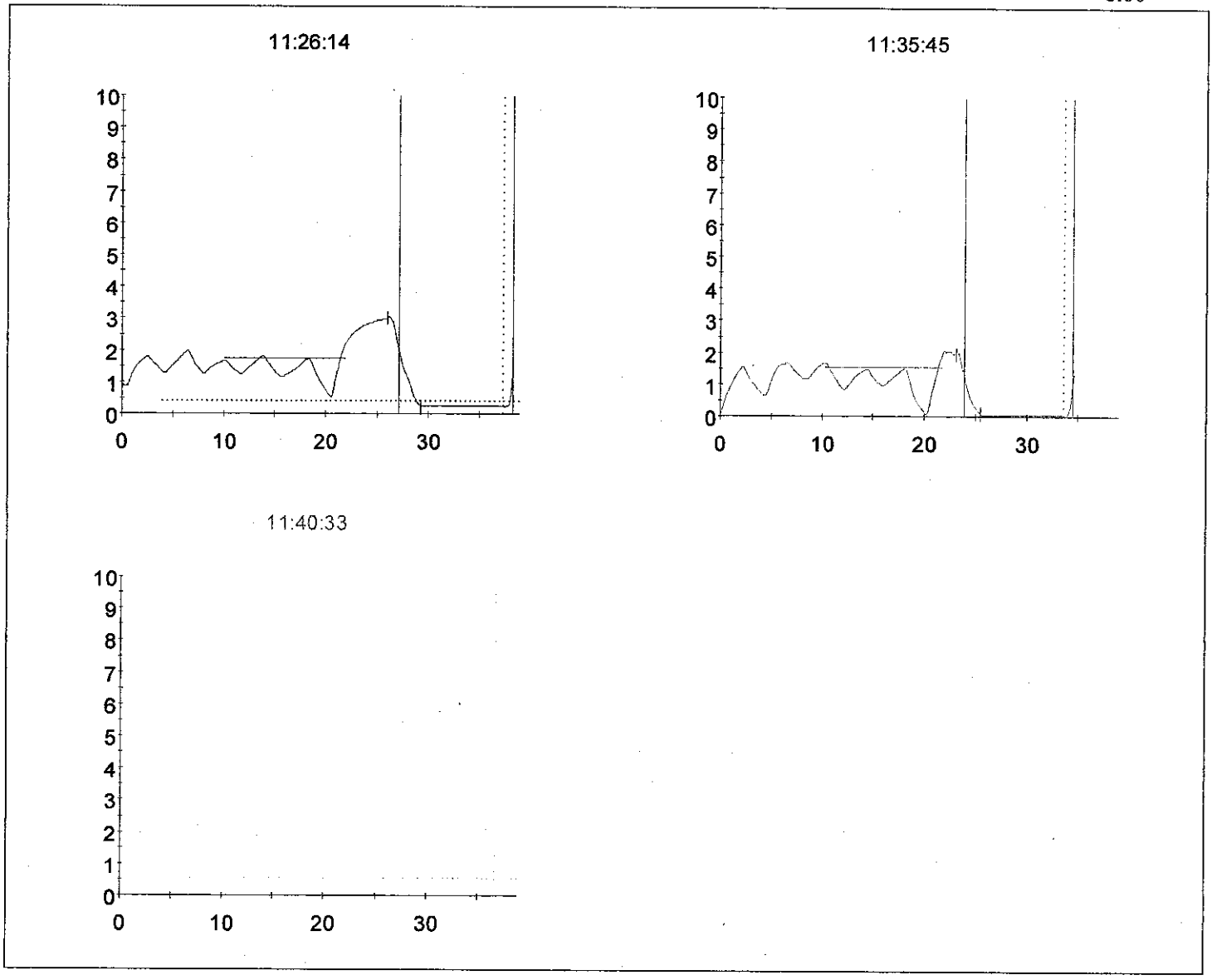
Doctor:	G. Fino, M.D.	Weight:	264.00	Sex:	Male	Race:	Black

Time	Select	RpLp	Test Mode	Codes	Protocol	DLCOunc absolute	DLCOunc % p/c	DLCOcor absolute	DLCOcor % p/c	DL/VA absolute
Predicted						40.80		40.80		5.86
Pre										
11:26:14	*				Jones-Mea	27.72	68			5.63
11:31:06				Inspirat	Jones-Mea	24.43	60			6.23
11:35:45	*			Inspirat	Jones-Mea	26.06	64			6.88
11:40:33	*				Jones-Mea	24.60	60			5.65
AVG			Pre/Baseline			26.12	64			6.00



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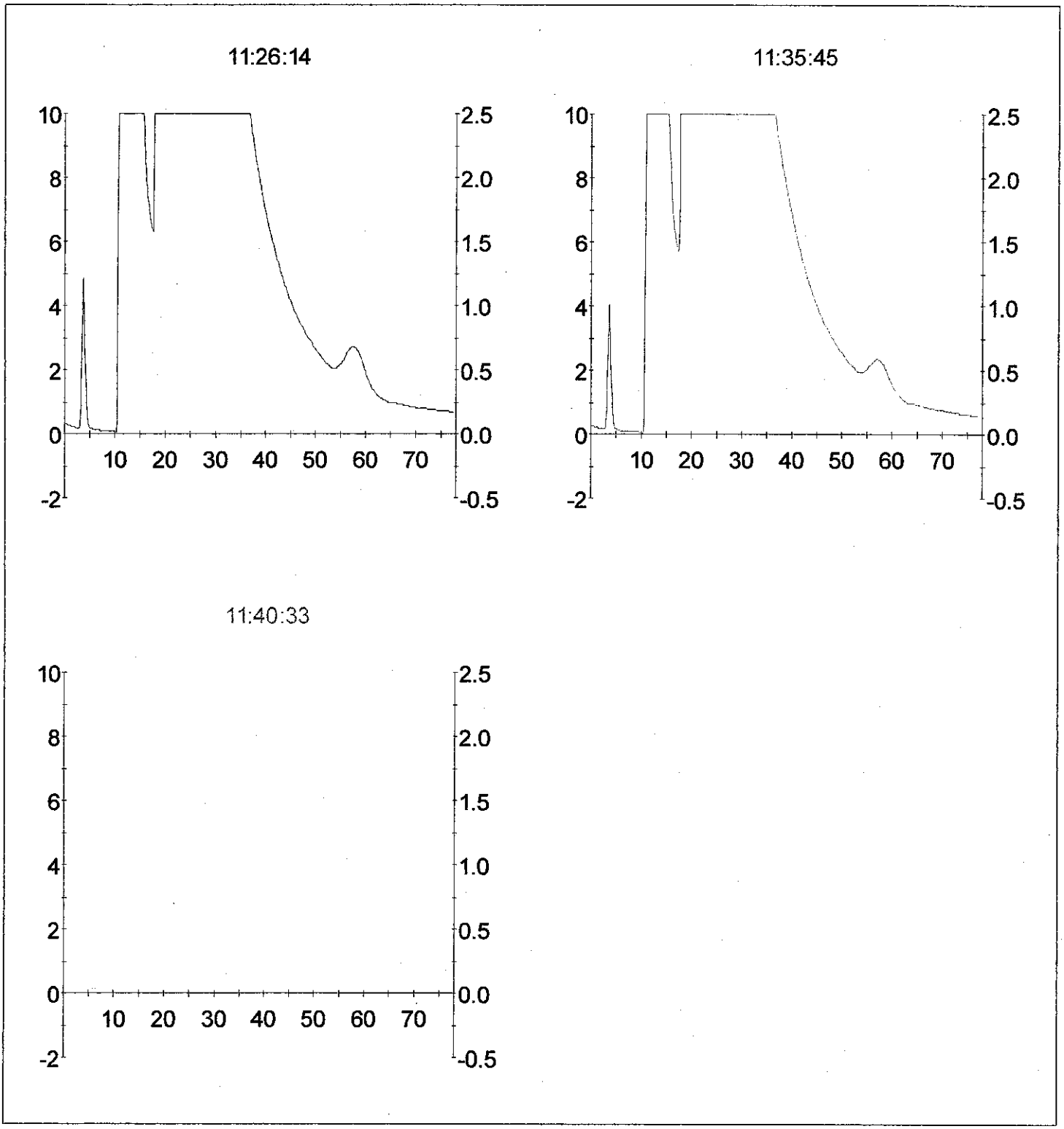

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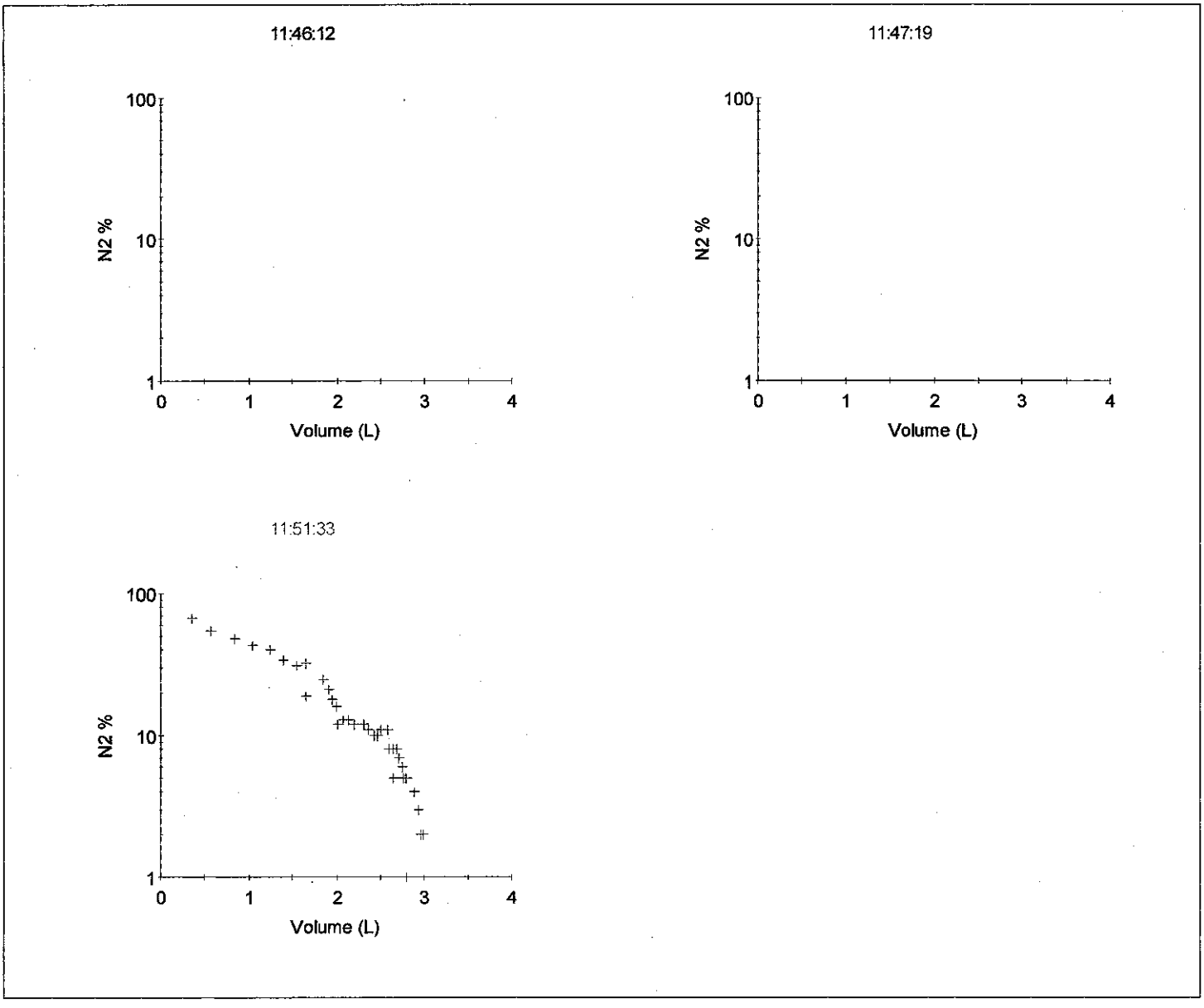
Doctor:	G. Fino, M.D.	Weight:	264.00	Sex:	Male	Race:	Black

Time	Select	RpLp	Test Mode	FRC (N2) absolute	FRC (N2) % p/c	RV (N2) absolute	RV (N2) % p/c	TLC (N2) absolute
Predicted				3.45		1.92		7.33
Pre								
11:46:12	*							
11:47:19	*							
11:51:33	*			2.94	85	2.38	124	5.32
AVG			Pre/Baseline	2.94	85	2.38	124	5.32



SIGGERS,KEVIN
MR#:881957 SEX:M AGE:36Y BIRTH:08/22/1970
DOCTOR:FINO, GREGORY J., M.D.
1000 BOWER HILL RD. SUITE 211
PITTSBURGH PA 15243

ST CLAIR HOSPITAL LABORATORY
1000 BOWER HILL ROAD
PITTSBURGH, PA 15243
MARTHA R. CLARKE,MD, MEDICAL DIRECTOR

========== PHYSICIAN COPY FOR DR: FINO, GREGORY J., M.D. ==========

T9258 COLL: 01/02/2007 10:14 REC: 01/02/2007 10:16

COMP METABOLIC			
SGOT/AST	33	[0-50]	U/L
SGPT/ALT	26	[0-50]	U/L
ALKALINE PHOSPHAT	67	[43-122]	U/L
BILIRUBIN TOTAL	0.7	[0.2-1.3]	MG/DL
PROTEIN	7.9	[6.0-8.4]	G/DL
ALBUMIN	4.2	[3.5-5.0]	G/DL
CALCIUM	9.1	[8.0-10.2]	MG/DL
GLUCOSE	109	[70-110]	MG/DL
BUN	11	[8-25]	MG/DL
CREATININE	1.1	[0.6-1.5]	MG/DL
GFR(CAUCAS/OTHER)	>59	[>59]	ML/MIN
GFR(AFRICAN AMER)	>59	[>59]	ML/MIN
SODIUM	136	[133-145]	MMOL/L
POTASSIUM	3.9	[3.5-5.0]	MMOL/L
CHLORIDE	100	[96-108]	MMOL/L
CO2	29	[22-30]	MMOL/L
ANION GAP	@7	[8-16]	MMOL/L
CBC HEMOGRAM			
WBC	6.9	[4.8-10.8]	K/UL
RBC	4.82	[4.7-6.2]	M/UL
HEMOGLOBIN	14.6	[14.0-17.0]	GM/DL
HEMATOCRIT	@40.6	[42.0-52.0]	%
MCV	84.2	[78.0-94.0]	FL
MCH	30.3	[25.0-35.0]	PG
MCHC	36.0	[31.0-36.5]	G/DL
RDW	13.3	[12.9-14.9]	%
PLATELET	286	[130-460]	K/UL
MPV	8.1	[7.4-10.4]	FL
DIFF,ELECTRONIC			
ABSOLUTE NEUTROPH	4.3	[1.5-6.6]	K/UL
ABSOLUTE LYMPHOCY	2.0	[1.5-3.5]	K/UL
ABSOLUTE MONOCYTE	0.3	[0-0.9]	K/UL
ABSOLUTE EOSINOPH	0.4	[0-0.6]	K/UL
ABSOLUTE BASOPHIL	0.1	[0-0.1]	K/UL
NEUTROPHIL	62.2	[40-75]	%
LYMPHOCYTE	26.7	[20-40]	%
MONOCYTE	4.2	[1-8]	%
EOSINOPHIL	@6.1	[0-5]	%
BASOPHIL	0.9	[0-1]	%

PAGE:1
1TIME
* = CRITICAL VALUE
@ = OUTSIDE NORMAL RANGE
END OF REPORT

FINO, GREGORY J., M.D.
1000 BOWER HILL RD. SUITE 211
PITTSBURGH PA 15243

[redacted]

LAB-208(7/98)

CLINICAL & OCCUPATIONAL PULMONARY ASSOCIATES, LLC

Gregory J. Fino, MD, FCCP

St. Clair Hospital
1000 Bower Hill Road, Suite 211
Pittsburgh, Pennsylvania 15243-1899

Telephone (412) 942-2025
Fax (412) 942-2032
Email gregory.fino@stclair.org

PATIENT SIGGERS, KEVIN

DATE 1-2-07

PULSE OXIMETRY

100/ RA

CC = 1 ppm

0.2 COHb

tests.do

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Gregory J. Fino, MD, FCCP

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January 22, 2007

Michael C. Colville
Assistant U.S. Attorney
U.S. Department of Justice
U.S. Post Office & Courthouse
700 Grant Street
Suite 4000
Pittsburgh, PA 15219

RE: Myron Ward v. United States
C.A. No. 04-11E
SSN: 579-96-8834
DOB: 7/7/70
OIME: 1/8/07

Dear Attorney Colville:

I examined Mr. Ward on January 8, 2007.

Patient Profile

Mr. Ward was born in 1970 and was 36 years old. His only medication was Nasonex - for chronic sinusitis. He has never used inhalers for his lungs.

He never smoked.

Occupational History

Mr. Ward worked at Unicor from April of 2002 until October of 2003. He helped with the cutting of the Micore board and was exposed to a lot of dust. He was also exposed to the dust from cutting particle board, and fumes from a glue used for the laminate - Lokweld. He was provided paper masks, but he only "sometimes" used them.

He denied any breathing problems prior to working at Unicor. He noticed breathing problems after he had been working there for about 6 months. He started to notice nasal congestion at night and a runny nose during the day. He also noted coughing at night when he would lie down. He had headaches and developed some conjunctivitis as well as episcleritis. He noted pruritis of the chest and the back.

Since he stopped working, the skin complaints are gone. He still has the coughing at night time and the chronic sinusitis.

He also stated that he can no longer run, and he has shortness of breath. He used to run 3 miles per day, but now he has to run a little bit - and then walk.

Past Medical History

1. Biopsy of lump on right side of neck - not cancerous
2. History of sinus problems; has had rhinitis
3. History of hemorrhoids

He has no history of pneumonia, tuberculosis, emphysema, asthma, bronchitis, bronchiectasis, or frequent colds. There is no history of fractured ribs.

Family History

There is no family history of lung disease. His paternal grandmother had a history of cancer. There is also a family history of heart problems (father died of a heart attack).

Review of Systems

Neurologic:	No headaches or seizures
GI:	No history of chronic gastrointestinal disease
CVS:	No history of cardiovascular disease
MS:	No chronic musculoskeletal problems
Endocrine:	No diabetes or thyroid disease

Physical Examination

General:	Well-developed, well-nourished Black man in no acute distress, oriented X 3
Heart Rate:	66
Blood Pressure:	136/68
Respiratory Rate:	14
Height:	68" without shoes
Weight:	150.6 lbs without shoes
Skin/Nails:	No cyanosis, clubbing, or edema
Neck:	Supple with a midline trachea; no thyromegaly
HEENT:	Unremarkable
Lungs:	Clear to auscultation and percussion on a tidal volume breath and a forced expiratory maneuver without wheezes, rales, rhonchi, or rubs
Heart:	Normal S1 and S2 without murmurs, gallops, or rubs
Abdomen:	No organomegaly
Peripheral Pulses:	2+ and equal
Extremities:	Negative
Edema:	Negative
Neurological Exam:	Intact

Chest X-Ray

A two-view chest x-ray was performed in conjunction with this examination. The chest x-rays were compared to the revised 2000 ILO classification films.

There were no pleural and no parenchymal abnormalities consistent with an occupationally acquired pneumoconiosis.

Classification: 0/0

Pulmonary Function Testing

The American Thoracic Society, in conjunction with the European Respiratory Society, has published a follow-up article to their 1991 article on selection of reference values and interpretative strategies in pulmonary function testing.

The original 1991 article is entitled Lung Function Testing: Selection of Reference Values And Interpretative Strategies **(AM REV RESPIR DIS 1991; 144:1202-1218).** The more recent article is entitled Interpretative Strategies for Lung Function Tests **(EUR RESPIR J 2005; 26:948-968).**

The following consensus recommendations have been issued in the 2005 consensus statement:

- ✓ If the patient's age or height is outside the limits of the reference population, a statement in the interpretation should indicate that an extrapolation has been made.
- ✓ The practice of using 80% as a fixed value for the lower limit of normal can lead to important errors when interpreting lung function in adults. The practice of using 0.70 as a lower limit of the FEV1/FVC ratio results in a significant number of false positive results in males aged greater than 40 years and females greater than 50 years, as well as in a risk of over diagnosis of chronic obstructive pulmonary disease in asymptomatic elderly never smokers.
- ✓ Volume corrections should be made for African-Americans and Hispanics when measuring spirometry. Values for lung volumes are, on average, 12% lower in African-Americans than in Caucasians.

- ✓ Recommended spirometric reference equations come from the National Health and Nutrition Examination Survey (NHANES III) published in 1999 **(AM J RESPIR CRIT CARE MED 1999; 159:179-187).**

- ✓ Recommended lung volume reference equations were published in 1995 **(EUR RESPIR J 1995; 8:492-506).**

- ✓ A single set of diffusing capacity reference values could not be recommended. There were two commonly used equations referenced, one of which has been utilized since its publication in 1981 **(AM REV RESPIR DIS; 123:185-189).**

The earlier consensus statement also recommended abandoning the 80% cut off as normal and the 70% cut off for the FEV1/FVC. The new 2005 statement paper goes one step further and has recommended utilization of one set of reference equations for spirometry, one for lung volumes and then one of two for the diffusing capacity. Having reviewed these new recommendations and having reviewed the source material, I believe that it is medically reasonable to follow the recommendations in the statement papers.

I have included with the pulmonary function studies that are performed in conjunction with my examinations a new summary for the spirometry, lung volumes and diffusing capacity. This summary utilizes the above noted recommendations for the spirometry, lung volume and diffusing capacity reference equations.

Spirometry

The spirometry was invalid because of a premature termination to exhalation and a lack of reproducibility in the expiratory tracings. There was also a lack of an abrupt onset to exhalation. The values recorded for this spirometry represent at least the minimal lung function that this man could perform and certainly not this man's maximum lung function. (References: (1) Standardization of Spirometry. *A.R.R.D.* 1987; 136:1285-1298. (2) ATS Statement-Snowbird Workshop on Standardization of Spirometry. *A.R.R.D.* 1979; 119:831-838. (3) Statement on Spirometry. *Chest* 1983; 83:547-550. (4) ATS/ERS Task Force: Standardization of Lung Function Testing - Standardization of Spirometry. Eur Respir J 2005; 26: 319-338.)

Lung Volumes

The lung volumes were invalid.

Diffusing Capacity

Eight attempts were made, but none were acceptable.

Oxygen Saturation

Normal

Carboxyhemoglobin Level

Normal

Laboratory Results

Liver function and renal function studies were normal, as was his complete blood count.

Medical Record Review

In conjunction with this evaluation, I reviewed the following information:

1. Background information which included:

   - The Microbac Indoor Airy Quality Survey dated 7/31/01.
   - The Declaration of Michael Salerno, dated 1/19/05, with detailed information regarding the ventilation system.
   - The McKean timeline, which identified when and where the Plaintiff worked within the UNICOR Factory.
   - Material Safety Data Sheets for Micore Board and Lokweld.
   - The OSHA Inspection Report and supporting documentation.

   Micore Board is a man-made product which contains man-made vitreous fiber, expanded perlite, starch, recycled paper, kaolin and crystalline silica.

Lokweld is a sprayed grade adhesive used for laminate. It contains acetone, toluene, hexane isomers, and N-hexane.

In a letter dated August 20, 2003, Mr. Stranahan (from OSHA) discussed the results of air monitoring to evaluate worker exposures to airborne dust concentrations. He stated that the "results showed no worker's exposure exceeded 10% of the relevant exposure limit." He did recommend a number of steps that could be voluntarily taken to eliminate or further reduce the workers' exposure to dust. No respirable silica was found.

2. A copy of the Second Amended Complaint.

3. The Declaration of Ned Watson, Correctional Counselor, dated 7/7/04.

4. The Plaintiff's Affidavit dated 6/17/05.

5. The Declaration of Stephen Housler, Safety Manager, dated 1/25/06.

6. The Declaration of Martin Sapko, Factory Manager, dated 1/25/06.

7. The Declaration of Debora Forsyth, Associate Warden, dated 1/30/06.

8. The Declaration of Douglas Goldring, Assistant General Counsel, dated 1/30/06.

9. A true and correct copy of the Plaintiff's medical records attached to Mr. Goldring's Declaration of 1/30/06.

10. The deposition transcript of Myron Ward dated 11/1/06.

11. In addition to the information noted above, I also had an opportunity to review miscellaneous records on CD ROMS that accompanied the files forwarded to my office.

Diagnosis

Normal Pulmonary Examination

Discussion

I find no evidence of a respiratory impairment or disability. This man's spirometry and lung volumes were both invalid.

The determination of pulmonary impairment and subsequent disability has been extensively researched in the American medical literature. In the late 1980s, there was a worldwide conference on the assessment of respiratory impairment sponsored by the National Institutes of Health. This was published in the American Review of Respiratory Disease in 1988 (ARRD 1988; 137:1505-1510). All of the participants agreed that symptoms of shortness of breath on effort and exercise intolerance were not reliable predictors of impairment. There was also agreement that a physical examination was not helpful in measuring pulmonary impairment. Lung function tests, however, were essential in assessing whether or not impairment was present and essential in rating its severity. Dr. Hans Weill commented that "resting lung function tests, usually spirometry, all are the cornerstone in the clinician's assessment of respiratory impairment, and provided they are technically sound, are generally believed to be adequate for ascertaining the presence of respiratory limitation. Likewise, it is generally believed that exercise limitation is not likely to be present in the face of normal or marginal resting lung function."

Similar statements have been issued by the American Thoracic Society and the American Medical Association with respect to guidelines for the evaluation of respiratory impairment. It is of utmost importance that valid lung function studies be performed. An invalid study does not represent the patient's maximum pulmonary capacity and cannot be used to assess impairment or disability. An invalid pulmonary function study indicates poor patient effort. The values recorded can only represent the minimum lung function of the patient.

There is no evidence of either chronic or accelerated silicosis based on the normal chest films.

This patient should have no fear of contracting silicosis in the future. First of all, there were no measurable levels of respirable silica noted by OSHA. Furthermore, it is well documented in the medical literature that at least 20 years of exposure to dust that is measurable and above the PEL is required before chronic silicosis occurs.

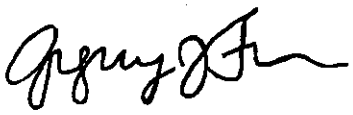
If Mr. Ward were my patient, I would not follow him for the subsequent development of silicosis, and I would assure him that he has no reason to worry about developing silicosis in the future.

I find no evidence of any chronic condition with reference to his eyes or throat or skin.

Conclusions

My conclusions have been reached with a reasonable degree of medical certainly. I find no evidence of any chronic condition of the lungs or pulmonary system related to Mr. Ward's alleged exposures. I find no evidence of a chronic condition with reference to the skin, eyes or nose.

Sincerely,



Gregory J. Fino, M.D., F.C.C.P.

GJF/kms

CLINICAL AND OCCUPATIONAL PULMONARY ASSOCIATES

GREGORY J. FINO, M.D., F.C.C.P.

PREDICTED VALUES BASED ON THE 2005 SPIROMETRY RECOMMENDATIONS

Recommendations from the ATS/ERS : INTERPRETATIVE STRATEGIES FOR LUNG FUNCTION TESTS EUR RESPIR J 2005; 26:948-968.

Name	Ward, Myron		MD	Fino
Ht	172.7	cm	Date	1/8/2007
Age	36	years	Race	African American

SPIROMETRY PREDICTED VALUES USING THE NHANES III STUDY

Spirometric Reference Values from a Sample of the General U.S. Population

AM J RESPIR CRIT CARE MED 1999; 159:179-187

TEST	PATIENT	PRED	%PRED	LLN	LLN%	POST	%PRED	BD %
FVC	3.08	4.16	74	3.27	79	4.11	99	33
FEV1	1.11	3.45	32	2.66	77	2.42	70	118
FEV1/FVC	36	83		72		59		
FEF25-75	0.43	3.74	11	2.06	55	2.15	57	400

REFERENCE VALUES FOR RV,FRC AND TLC - ATS WORKSHOP ON LUNG VOLUME MEASUREMENTS OFFICIAL STATEMENT OF THE EUROPEAN RESPIRATORY SOCIETY

EUR RESPIR J 1995; 8:492-506

L.V.	PATIENT	PRED	%PRED	LLN	LLN%	ULN	ULN%
TLC	9.74	5.91	165	4.71	80	8.09	137
RV	8.15	1.61	508	1.02	63	2.49	155
FRC	8.72	2.91	299	2.04	70	4.30	148
RV/TLC%	84	28	300	17	62	39	138

Prebronchodilator INVALID

FVC

FEV1

FEV1/FVC

FEF25-75

Post Bronchodilator

FVC

FEV1

Lung Volumes INVALID

FRC

TLC

RV

RV/TLC

PRE		POST	
FVC	3.08	FVC	4.11
FEV1	1.11	FEV1	2.42
FEV1/FVC	36	FEF25-75	2.15
FEF25-75	0.43	PRE	
TLC	9.74	RV/TLC%	84
RV	8.15		
FRC	8.72		

Gregory J. Fino, M.D.

St. Clair Hospital

Pulmonary Function Report

1000 Bower Hill Rd.
Pittsburgh, PA, 15243
Phone: 412-942-2000 **Fax:** 412-942-2024

Name:	Ward, Myron	ID:	881985	D.O.B.:	07/07/1970	Date:	01/08/2007
Tech:	T. Zeman, CRT, RPsgT.	Height:	68.00	Age:	36	Room:	Outpatient
Doctor:	G. Fino, M.D.	Weight:	150.60	Sex:	Male	Race:	Black

Diagnosis: SOB
Dyspnea: After severe exertion Cough: Non-Productive Wheeze: No Wheeze
Tbco Prod: Never Smoked Yrs Smk: Pks/Day: Yrs Quit:
Medications:
Pre Test Comments:
Post Test Comments: PFT Authors DLCO (Crapo), FVC (Nhanes III), FRC (ECCS). Albuterol MDI 2 puffs given. Eight attempts were made for DLCO, none of which were acceptable.

	Pre-Bronch			Post-Bronch		
	Actual	Pred	%Pred	Actual	%Pred	%Chng
---- SPIROMETRY ----						
FVC (L)	3.08	4.16	74	4.11	99	33
FEV1 (L)	1.11	3.45	32	2.42	70	119
FEV1/FVC (%)	36	83	43	59	71	64
FEF 25% (L/sec)	1.00	7.48	13	3.14	42	212
FEF 75% (L/sec)	0.42	2.04	21	2.14	105	410
FEF 25-75% (L/sec)	0.43	3.74	11	2.15	58	405
FEF Max (L/sec)	1.12	8.91	13	3.22	36	187
FIVC (L)	2.14					
FIF Max (L/sec)	1.33					
---- LUNG VOLUMES ----						
SVC (L)	1.59	4.87	33			
IC (L)	1.02	3.32	31			
ERV (L)	0.57	1.55	37			
FRC (N2) (L)	8.72	3.28	266			
RV (N2) (L)	8.15	1.82	448			
TLC (N2) (L)	9.74	6.72	145			
RV/TLC (N2) (%)	84	28	299			
Washout Time (min)	2.61					

St. Clair Hospital

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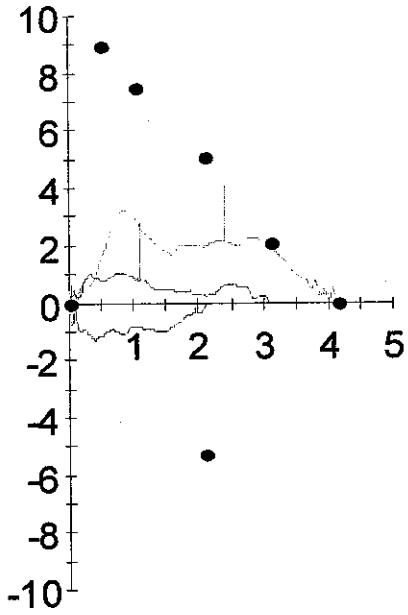
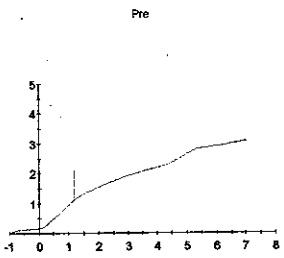
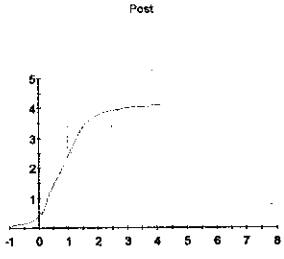
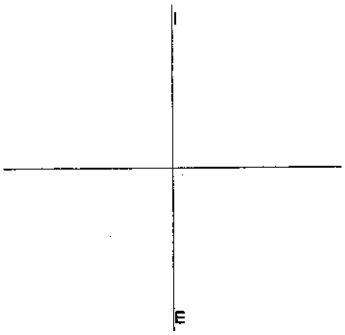


Pred Pre Post







St. Clair Hospital

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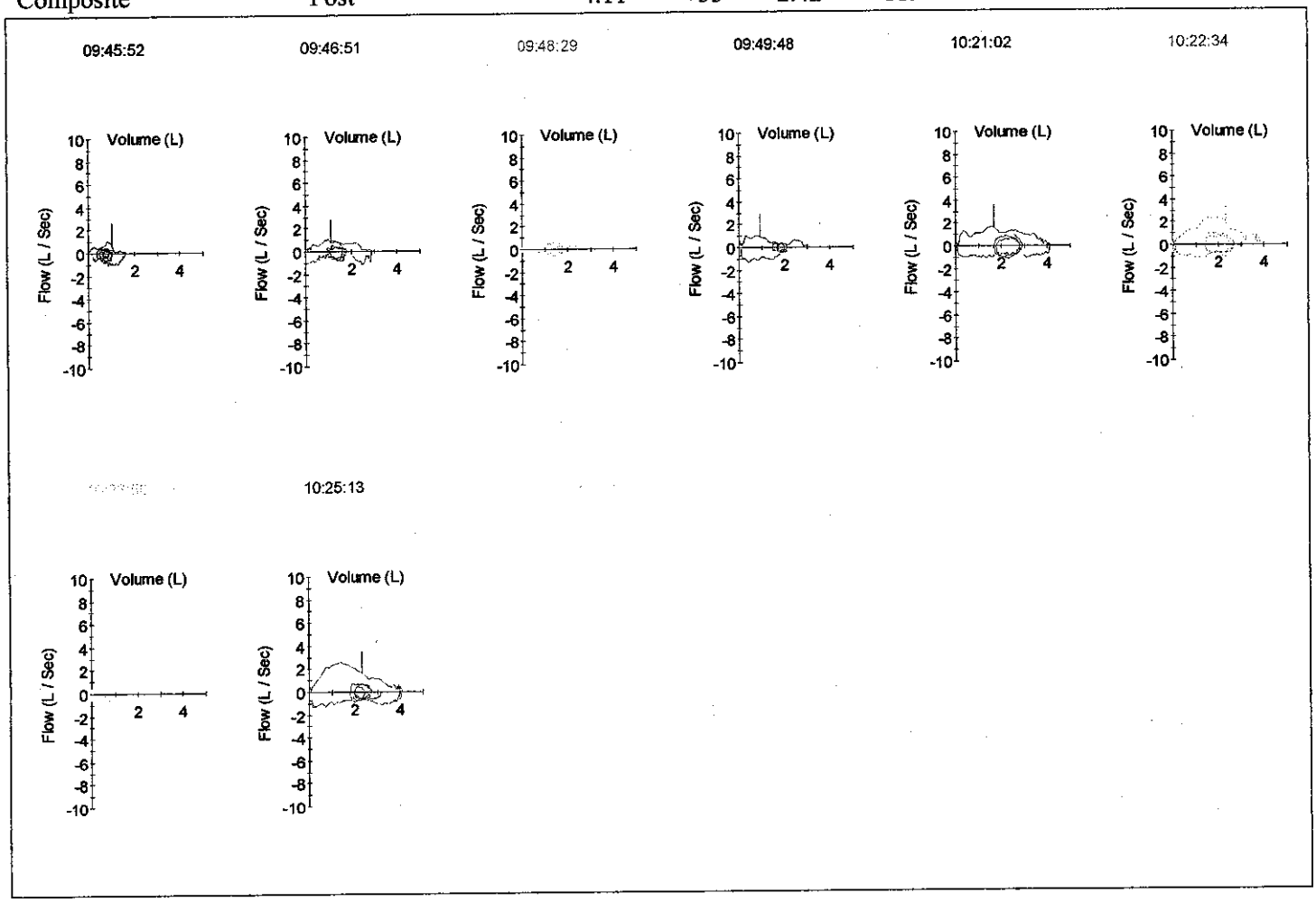
Doctor:	G. Fino, M.D.	Weight:	150.60	Sex:	Male	Race:	Black

Time				absolute FVC absolute	% p/c FVC % p/c	absolute FEV1 absolute	% p/c FEV1 % p/c	absolute FEV1/FVC absolute	absolute FEF 25-75% absolute
Pre									
09:49:48	*		back e	3.08	74	0.94	27	31	0.43
09:46:51	*		back e	2.88	69	1.11	32	38	0.77
09:48:29	*		back e	2.56	62	0.68	20	26	0.37
09:45:52	*		back e	1.61	39	1.03	30	64	0.45
Composite		Pre/Baseline		3.08	74	1.11	32	36	0.43
Post									
10:23:50	*		end of	4.11	+33	2.42	+119	59	2.15
10:25:13	*		back e	4.06	+32	2.34	+111	57	2.17
10:22:34	*			3.85	+25	2.35	+112	61	1.92
10:21:02	*		back e	4.11	+33	1.70	+53	41	1.25
Composite		Post		4.11	+33	2.42	+119	59	2.15



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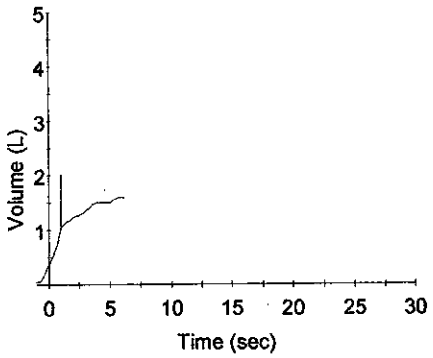

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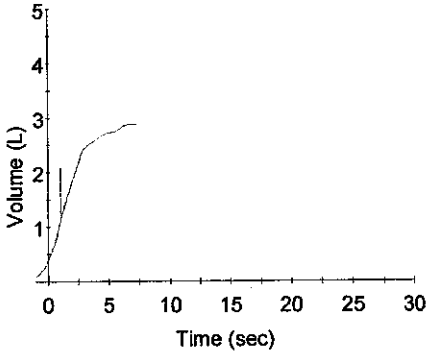

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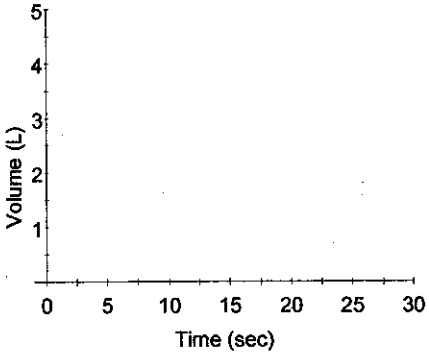

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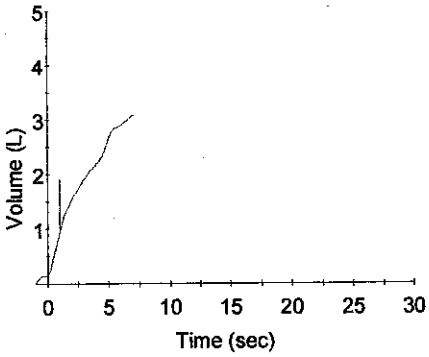

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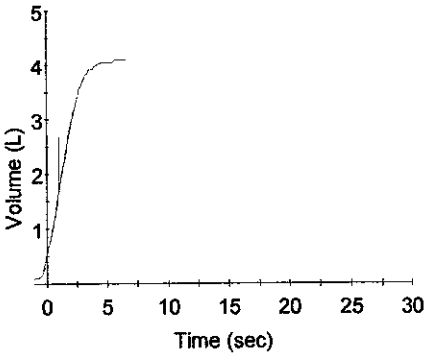

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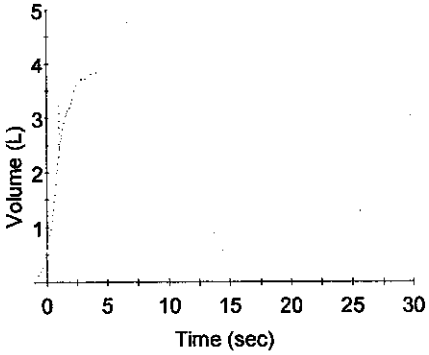

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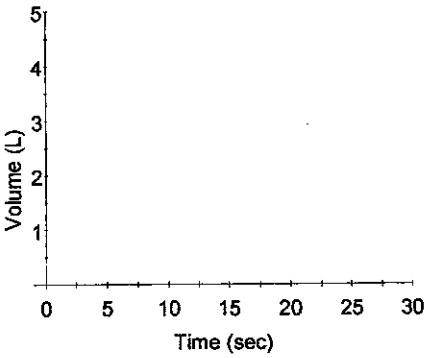

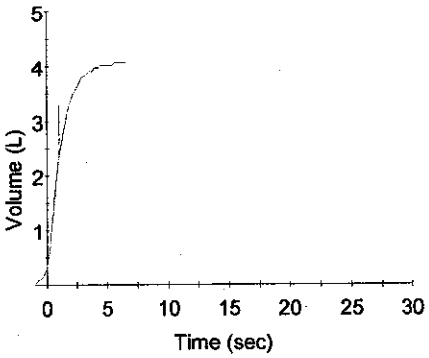

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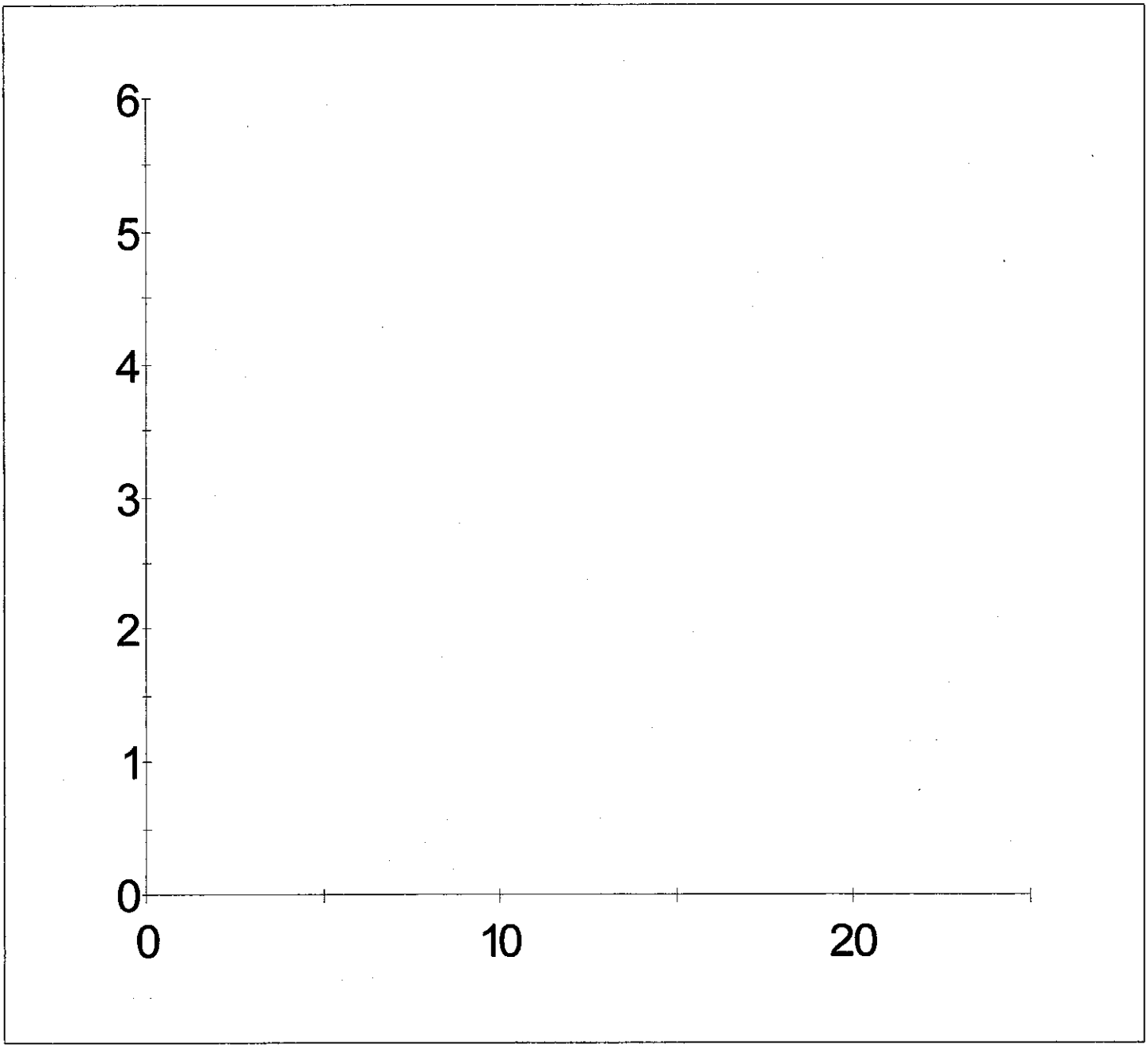
Doctor:	G. Fino, M.D.	Weight:	150.60	Sex:	Male	Race:	Black

Time	Select	RpLp	Test Mode	Codes	Protocol	DLCOunc absolute	DLCOunc % p/c	DLCOcor absolute	DLCOcor % p/c	DL/VA absolute
Predicted						37.63		36.95		5.86
Pre										
Post										



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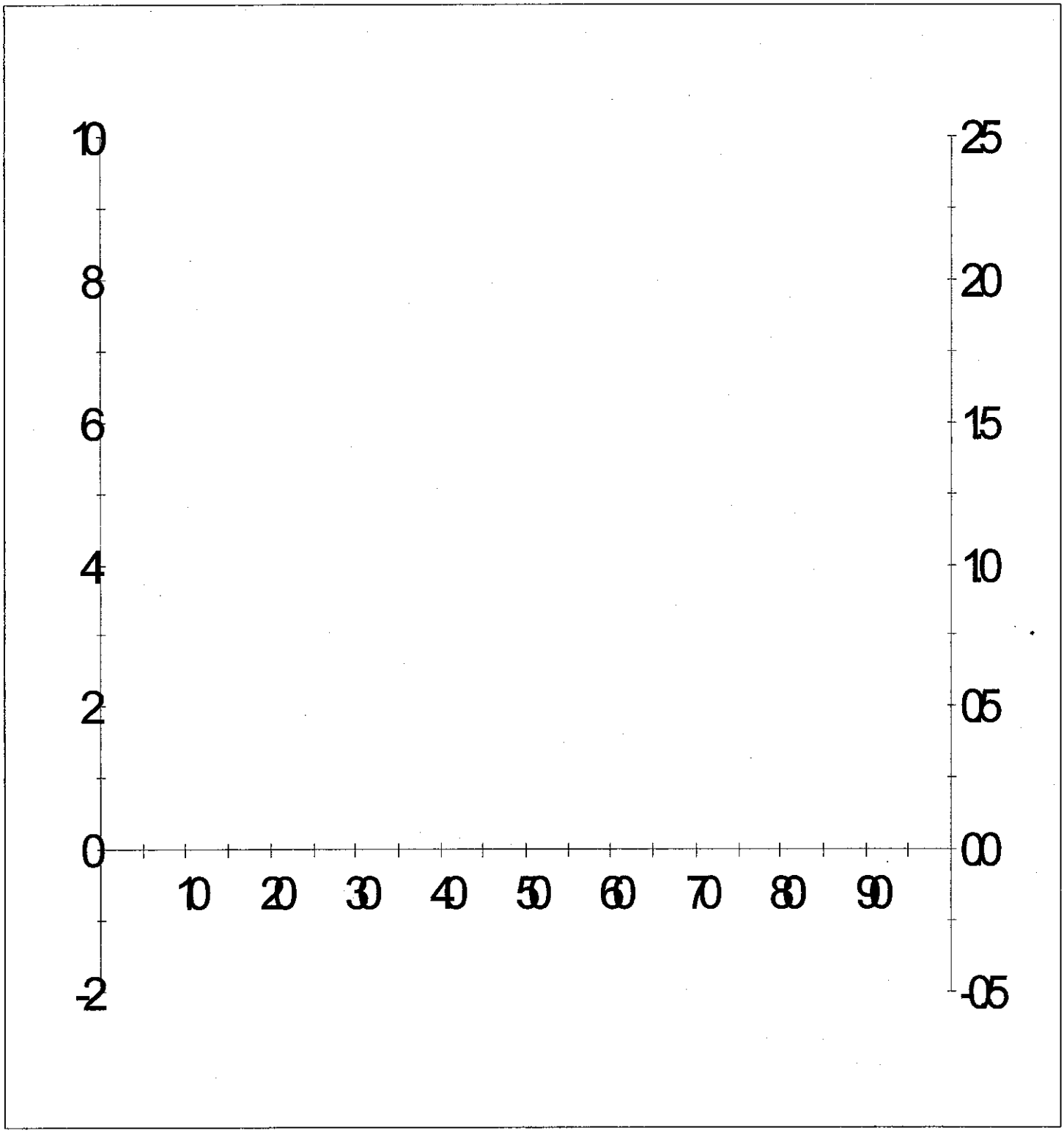

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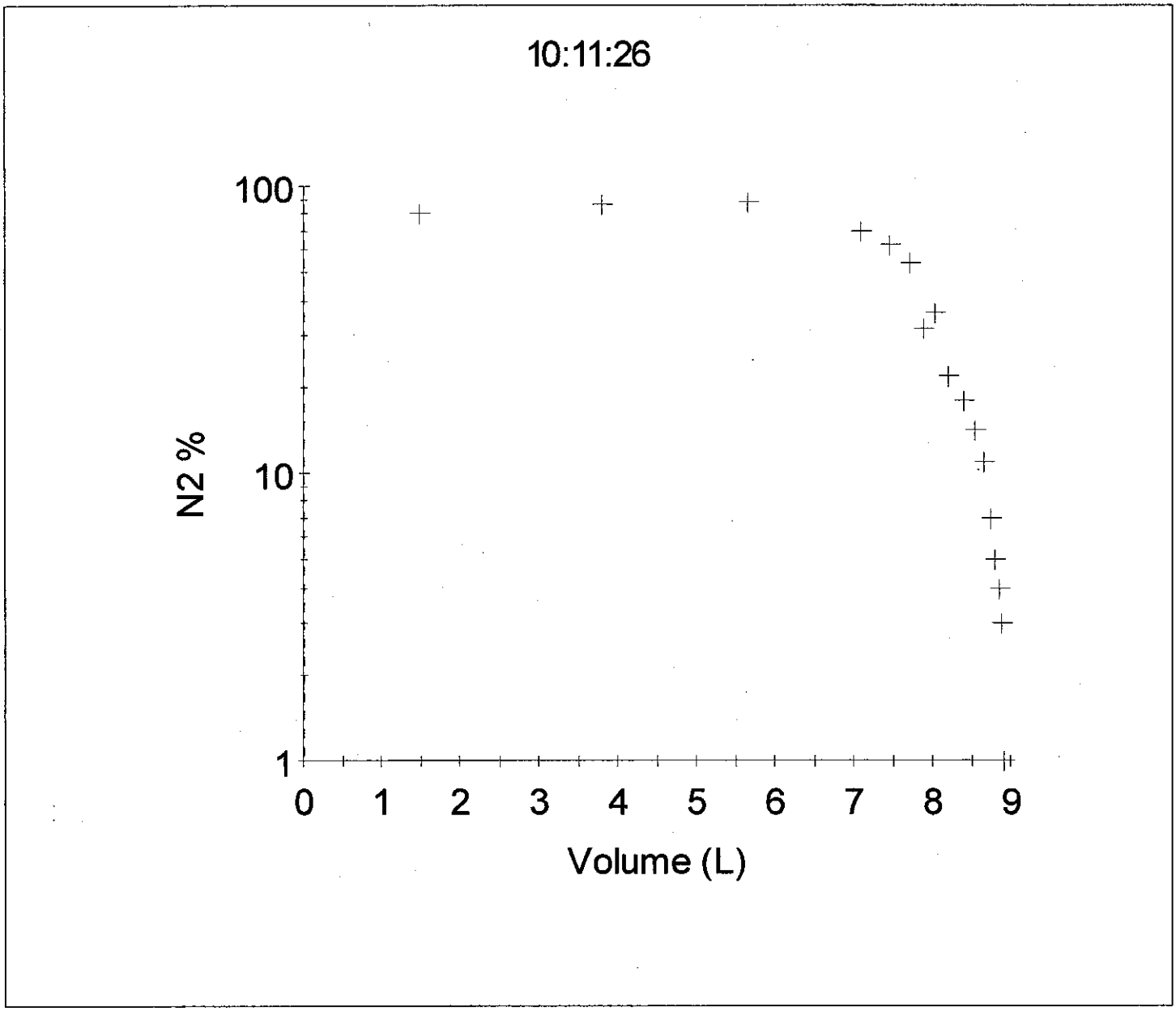
Doctor:	G. Fino, M.D.	Weight:	150.60	Sex:	Male	Race:	Black

Time	Select	RpLp	Test Mode	FRC (N2) absolute	FRC (N2) % p/c	RV (N2) absolute	RV (N2) % p/c	TLC (N2) absolute
Predicted				3.28		1.82		6.72
Pre								
10:11:26	*			8.72	266	8.15	448	9.74
AVG			Pre/Baseline	8.72	266	8.15	448	9.74
Post								



WARD,MYRON
MR#:881985 SEX:M AGE:36Y BIRTH:07/07/1970
DOCTOR:FINO, GREGORY J., M.D.
1000 BOWER HILL RD. SUITE 211
PITTSBURGH PA 15243

ST CLAIR HOSPITAL LABORATORY
1000 BOWER HILL ROAD
PITTSBURGH, PA 15243
MARTHA R. CLARKE,MD, MEDICAL DIRECTOR

========== PHYSICIAN COPY FOR DR: FINO, GREGORY J., M.D. ==========

M819 COLL: 01/08/2007 11:13 REC: 01/08/2007 11:15

COMP METABOLIC			
SGOT/AST	17	[0-50]	U/L
SGPT/ALT	9	[0-50]	U/L
ALKALINE PHOSPHAT	60	[43-122]	U/L
BILIRUBIN TOTAL	0.4	[0.2-1.3]	MG/DL
PROTEIN	7.7	[6.0-8.4]	G/DL
ALBUMIN	4.6	[3.5-5.0]	G/DL
CALCIUM	9.5	[8.0-10.2]	MG/DL
GLUCOSE	86	[70-110]	MG/DL
BUN	17	[8-25]	MG/DL
CREATININE	1.1	[0.6-1.5]	MG/DL
GFR(CAUCAS/OTHER)	>59	[>59]	ML/MIN
GFR(AFRICAN AMER)	>59	[>59]	ML/MIN
SODIUM	141	[133-145]	MMOL/L
POTASSIUM	4.0	[3.5-5.0]	MMOL/L
CHLORIDE	104	[96-108]	MMOL/L
CO2	29	[22-30]	MMOL/L
ANION GAP	8	[8-16]	MMOL/L
CBC HEMOGRAM			
WBC	4.9	[4.8-10.8]	K/UL
RBC	5.09	[4.7-6.2]	M/UL
HEMOGLOBIN	15.5	[14.0-17.0]	GM/DL
HEMATOCRIT	44.2	[42.0-52.0]	%
MCV	86.8	[78.0-94.0]	FL
MCH	30.5	[25.0-35.0]	PG
MCHC	35.1	[31.0-36.5]	G/DL
RDW	@12.7	[12.9-14.9]	%
PLATELET	197	[130-460]	K/UL
MPV	@6.7	[7.4-10.4]	FL
DIFF,ELECTRONIC			
ABSOLUTE NEUTROPH	2.8	[1.5-6.6]	K/UL
ABSOLUTE LYMPHOCY	2.0	[1.5-3.5]	K/UL
ABSOLUTE MONOCYTE	0.2	[0-0.9]	K/UL
ABSOLUTE EOSINOPH	0.0	[0-0.6]	K/UL
ABSOLUTE BASOPHIL	0.0	[0-0.1]	K/UL
NEUTROPHIL	58.1	[40-75]	%
LYMPHOCYTE	36.8	[20-40]	%
MONOCYTE	3.8	[1-8]	%
EOSINOPHIL	0.8	[0-5]	%
BASOPHIL	0.4	[0-1]	%

PAGE:1
1TIME
* = CRITICAL VALUE
@ = OUTSIDE NORMAL RANGE
END OF REPORT

FINO, GREGORY J., M.D.
1000 BOWER HILL RD. SUITE 211
PITTSBURGH PA 15243

[redacted]

LAB-208(7/98)

CLINICAL & OCCUPATIONAL PULMONARY ASSOCIATES, LLC

Gregory J. Fino, MD, FCCP

St. Clair Hospital
1000 Bower Hill Road, Suite 211
Pittsburgh, Pennsylvania 15243-1899

Telephone (412) 942-2025
Fax (412) 942-2032
Email gregory.fino@stclair.org

PATIENT WARD, MYRON

DATE 1-8-07

PULSE OXIMETRY

100% on Room Air

CC = 1 ppm

0.5 COHb

tests.do